Death Claim Document Required for Insured Person or Premium Payor

Agent information required

Agent Name/Agency Leader Name..... Agent Code..... Telephone No.....

Unit Name..... Branch..... Fax No.....

Policy Number..... Name of Insured.....

Name of Premium Payor.....

Dear Beneficiary

Please accept our heartfelt condolences on the loss of your loved one. To avoid any delay in processing your claim, please fill in the form completely and submit it along with the following documents, and mark ☑ on the items you send to us.

If death is due to natural cause (Illness)

- ☐ 1. Death claim form
- ☐ 2. Attending physician's statement
- ☐ 3. A certified true copy of death certificate
- ☐ 4. A certified true copy of the identification card of the deceased
- ☐ 5. A copy of the household registration of the deceased with the "deceased" stamp
- ☐ 6. Certified true copies of identification cards of all beneficiaries
- ☐ 7. Certified true copies of the household registration of all beneficiaries
- ☐ 8. Consent and Verification of Status for Compliance with the US Foreign Account Tax Compliance Act (FATCA Form) of all beneficiaries
- ☐ 9. Life Insurance Policy or Personal Accident Insurance Policy together with Care Card
- ☐ 10. Document showing the outstanding balance of the insured at the date of death (in case the bank or financial institution is held on behalf of the creditor beneficiary)
- ☐ 11. 3 Letters of Consent and Authorization with the signature of beneficiary
- ☐ 12. Others, please specify (Certificate of Name-Surname Change, Marriage Certificate, etc.).....

Note: All documents must be certified true copies by the beneficiary

If death is due to an accident or unnatural causes 1-11 of the above specified documents, and please include the following.

- ☐ 13. Copy of the autopsy report and/or copy of forensic autopsy report (if any), certified by the commissioned police officer or the pathologist or coroner
- ☐ 14. Copy of the police report

In case premium payor is deceased or the beneficiary is a minor

- ☐ 15. Copy of identification card of the legal guardian (in case of non-parent, please attach a copy of the Court's order appointing the guardian)

Submission of documents

All claims required documents can be submitted to any company branches across the country, or posted to Claim Department, FWD Life Insurance Public Company Limited, 14th floor, Sindhorn Building Tower 3, 130-132 Wireless Road, Lumpini, Pathumwan, Bangkok 10330

Submitter..... Recipient.....

Submission Date..... Received Date.....

FWD Life Insurance Public Company Limited
14th, 16th, 26th – 29th Floor, 130-132 Sindhorn Building Tower 3,
Wireless Road, Lumpini, Pathumwan, Bangkok 10330
Tax ID 0107563000304
P 1351 W fwd.co.th

Death Claim Form for Insured Person / Premium Payor

FWD insurance

1. Insured Information

Name of deceased.....Age.....Years ☐ as an insured person ☐ as a premium payor

Policy Number.....Last address No.....Moo.....Street.....Sub-District.....

District.....Province.....Postcode.....

2. Claimant

Full Name.....Age.....Years Occupation.....Nationality.....

Address for sending documents: No.....Moo.....Street.....Sub-district.....

District.....Province.....Postcode.....Telephone No.....

Relationship to the insured.....

Are you a beneficiary of this insurance policy? ☐ Yes ☐ No Exercise your right as.....

3. Payment method for claim settlement

☐ Cheque or draft to be mailed directly to the address specified above.

☐ Transfer the payment to the bank account (Please attach a copy of the front page of your bank passbook)

* Unit Linked Policy. All units of the underlying funds will be sold on the next working day(1) if the company received complete documents and approved a claim within 4 p.m. (If after 4 p.m, the units will be sold on the next working day.)

(1) Working day means company working day and also the day that the fund(s) can be traded.

4. Details of Illness before death

Please state the date the insured first complained of or gave indications of his/her illness.....

Please state symptoms presented.....

Please state the date the insured first consulted a physician for his/her last illness.....

Name of physician / Name of medical institution who attended to the insured.....

5. Names and addresses of all physicians who attended during his/her last illness or medical institutions which the insured was ever confined in for last illness, and during the start date of the coverage period or prior to that.

Name of Physician or Medical Institution	Address	Dates of treatment	Disease

6. Was the life of the deceased assured with other insurance company?

Name of Insurance Company	Policy Number	Date of Issue	Sum Insured

I hereby certify that such information in this form, documents and evidence that have been stated and submitted to the company are true and accurate in all respects to the best of my knowledge.

Signature.....Beneficiary Signature.....Witness Signature.....Witness

Letter of Consent

I hereby give consent to the attending physician (s) or medical institution (s) that has or had provided the deceased with medical treatment, to disclose the medical treatment history or other details pertaining to the treatment, include give consent to an organization or person who performs an autopsy to disclose autopsy report to FWD Life Insurance Public Company Limited or a representative of the Company. A photocopy or copy of this authorization is regarded as equally effective and complete as the original.

Signature.....Beneficiary (Claimant) Date.....

Attending Physician's Statement

FWD insurance

Name of Deceased..... Age..... Years

Address..... Occupation.....

1. How long have you known the deceased?	.....
2. 2.1 When did the deceased first consult you or receive treatment from you? And for what disease? 2.2 Did the deceased receive any treatment from any other physicians for these symptoms before you? If yes, please specify.	2.1 .... 2.2 ....
3. 3.1 Did you attend the deceased during his/her last illness? 3.2 If yes, for what disease? 3.3 Date of your first attendance 3.4 Date of your last attendance	3.1 ..... 3.2 ..... 3.3 ..... 3.4 .....
4 4.1 Place of Death 4.2 Date of Death	4.1 ..... 4.2 .....
5. 5.1 What was the primary cause of death? 5.2 What was the duration between the onset of the illness/condition and death? 5.3 In your opinion, how long did the deceased suffer from this disease/symptom?	5.1 ..... 5.2 ..... 5.3 .....
6. Did the deceased suffer from any other significant diseases? When?	.....
7. For how long the deceased needed to stay at home or had been incapable of engaging in profession?	....
8. Was there any special cause of the deceased's death, either direct or indirect, in his/her habits, occupation or residence?	....
9. 9.1 Was the death of the deceased due to suicide? 9.2 Was the deceased under the influence of alcohol or narcotics? / If yes, did they contribute to the fatal disease? 9.3 Did the deceased get a blood alcohol test? (If yes, please specify the result.) 9.4 Did the deceased get a drug or toxic substance test? (If yes, please specify the testing place and the result.) 9.5 Was there any other cause of the deceased's death, either direct or indirect? Or was the cause of death due to his/her habits, occupation, or residence?	9.1 ..... 9.2 .... 9.3 ..... 9.4 .... 9.5 ....
10. Did the deceased get test for HIV? If yes, how was the test result?	.....
11. Was an autopsy done? If yes, please state.	.....

Please state the name and address of all physicians or other practitioners who attend to the deceased during the past three years, that are known to you.

Name	Address	Disease or Condition, and Date of Attendance
.....	.....	.....
.....	.....	.....

I,..... Medical License No..... Qualification.....

Hospital / Medical Institution..... Address.....

..... Telephone No..... Date examined.....

hereby certify that the above statement in truthful in all aspects.

(Affix with medical center's seal)

Signature..... Physician

(.....)

The Company shall not accept responsibility for any costs and expenses relating to all required documentation which may incur.

Letter of Consent and Authorization

Written at.....

Date.....Month.....Year.....

I (Mr. Mrs. Ms.).....Age.....years, as a statutory heir/beneficiary/legal representative of beneficiary under the insurance policy of.....

The insured, hereinafter referred to as "the deceased" hereby authorize **FWD Life Insurance Public Company Limited** to copy, duplicate or request for a certification of inpatient and outpatient medical records or other medical records relating to all types of medical conditions, including diagnostic test results, X-ray analysis, blood test, saliva testing or physical examination to find the cause of diseases, including all medical expenses from physician(s), clinic(s), government hospital(s), private hospital(s) or health center(s) which the deceased was admitted to, including the deceased's personal history and any government documents which related to the deceased from individual person, juristic person or any government agencies. And the Company has the right to act on my behalf until the related processes are completed.

As for all actions mentioned above, I wish and give consent to physician(s) and/or medical professions of clinic(s), government hospital(s), private hospital(s), health center(s) or any government agencies to disclose the deceased's entire medical record and document(s) for the purpose and benefit of the filing a death claim under the deceased's insurance policy with **FWD Life Insurance Public Company Limited.**

If I and/or the deceased should suffer an any damage, whether directly or indirectly, I give up my right completely to blame or sue or claim compensation from physician(s) and/or medical professions of clinic(s), government hospital(s), private hospital(s), health center(s), or any government agencies which has been disclosed or conducted under the scope of this letter of consent. Any action of the authorized person under the scope of this letter of consent is bound to me legally and deems to act on my behalf in all respects.

I hereby, fully acknowledge and understand all the above statements, which concur in the proper manner of the intention and purpose in all respects of my consent. I affix my signature herewith in the presence of the witness.

Signature.....Grantor/Consent Giver

(.....)

Signature.....Authorized person

(.....)

Signature.....Witness/Insurance Agent

(.....)

Signature.....Witness

(.....)

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Form for Declaration of Status as U.S. or Non-U.S. Person
For Individual

Beneficiary's Full Name.....**Policy No.**.....

☐ Identity Card ☐ Passport No.....Expiry Date.....

Consent and Verification of Status for Compliance with the US Foreign Account Tax Compliance Act (FATCA)

1. Confirmation of Status

a. I am a U.S. Citizen, **or** I was born in the U.S. (or U.S. Territory) and have not legally surrendered U.S. citizenship, **or** I am a Green Card holder, **or** I am a U.S. resident for U.S. tax purposes?

☐ No ☐ Yes

b. I have a current U.S. residence address, **or** I have a power of attorney, **or** signatory authority for granted to person with U.S. address?

☐ No ☐ Yes

2. Consent and agreement

I acknowledge that **FWD Life Insurance Public Company Limited ("the Company")** is subject to and required to comply with the Foreign Account Tax Compliance Act (FATCA). In this regard, I provide my consent and agree that the Company may do either the following for the compliance with FATCA.

a. Provision and Disclosure of Information and Notice of Information or Status Change

I provide my express consent that the Company shall have the right to provide such personal data and information to both domestic and foreign governmental authorities in compliance with FATCA law.

I agree to provide additional information to respond to the Company request within a specific time frame.

I agree to notify the Company of any change of my status or information already notified the Company if the status or information which has been changed is related to the US within 30 days from the date of such change.

b. Result of failure to give information

In the event that I fail to provide the information, I consent and agree to allow the Company to withhold tax from any sum I or beneficiary or the insured's heir is entitled to receive under the casualty insurance policy as stipulated in the FATCA.

If the Company exercises its right to withhold tax under the FATCA, in case I have failure to give information, the Company must send me a notice that I shall show any relevant documents or evidences or a letter to the Company, to confirm that I don't have a duty to pay taxes in U.S. within 30 days since receiving notice letter. If I fail to provide the information, the Company shall withhold tax from any sum I am entitled to receive under the casualty insurance policy as stipulated in the FATCA.

And the Company shall send the notice to the address given by me to the company.

Date..... Month.....Year.....

Signature.....

(.....)

Witness / Insurance Agent

Signature.....

(.....)

Beneficiary

Signature.....

(.....)

☐ Father/Mother ☐ Legal representatives of the beneficiary

FWD Life Insurance Public Company Limited
14th, 16th, 26th – 29th Floor, 130-132 Sindhorn Building Tower 3,
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Form for Declaration of Status as a U.S. or Non-U.S. Person For Entity/Juristic Person

FWD insurance

Policy No......

Beneficiary's Name (Juristic person): ☐ **Co., Ltd.** ☐ **LP.** ☐ **Partnerships**.....**Name of Entity**.....

By Director or Managing Partner, the Authorized Person of the Insured (Juristic Person) or Authorized Person

Full Name.....**Identification card**.....

Identity document ☐ ID Card Expiry Date..... ☐ Passport No.....Expiry Date.....

Consent and Verification of Status for Compliance with the US Foreign Account Tax Compliance Act (FATCA)

1. Confirmation of Status

1.1 I am the entity that is Exempt Beneficial Owner or Deemed Compliant Financial Institution e.g. foreign government, organization of foreign government, international organization, organization representative, Bank of Thailand, Exempt retirement funds under FATCA, Entity wholly owned by exempt beneficial owners.

☐ **No** ☐ **Yes** (If you answer **'Yes'**, please complete Form **W-8BEN-E** of the Internal Revenue Service (IRS) only.)

1.2 Are you a U.S. entity or an entity that has registered or has been incorporated in the U.S.?

☐ **No** ☐ **Yes** (If you answer **'Yes'**, please complete Form **W9** of the Internal Revenue Service (IRS) only.)

1.3 I am the entity that is a financial institution under the definition of FATCA e.g. Depositary Corporations (bank, or similar like a bank), Custodian Institute, entity that conducting business related to investment (e.g. broker, investment manager and funds etc.) or insurance company.

☐ **No** ☐ **Yes** (If you answer **'Yes'**, please complete Form **W-8BEN-E** of the Internal Revenue Service (IRS) only.)

1.4 I am the Passive Non-Financial Entity (Passive NFE) under FATCA, that primarily has earned passive income from asset investment e.g. interest, dividends, rents, royalties, etc. equal to or more than 50% of total gross income, or held asset that generate passive income equal to or more than 50% of total asset, in the preceding fiscal calendar year.

☐ **No** ☐ **Yes** (If you answer **'Yes'**, please complete Form **W-8BEN-E** of the Internal Revenue Service (IRS) only.)

Please answer 'No' in 1.4 if you are any of the following:

Active Non-Financial Entities (Active NFE) as stated under FATCA e.g. a publicly traded entity, a non-profit organization, association, foundation, or an entity that is a non-financial start-up company that has been organized less than 24 months.

2. Consent and agreement

I acknowledge that **FWD Life Insurance Public Company Limited ("the Company")** is subject to and required to comply with the Foreign Account Tax Compliance Act (FATCA). In this regard, I provide my consent and agree that the Company may do either the following for the compliance with FATCA.

a. Provision and Disclosure of Information and Notice of Information or Status Change

I provide my express consent that the Company shall have the right to provide such personal data and information to both domestic and foreign governmental authorities in compliance with FATCA law.

I agree to provide additional information to respond to the Company request within a specific time frame.

I agree to notify the Company of any change of my status or information already notified the Company if the status or information which has been changed is related to the US within 30 days from the date of such change.

b. Result of failure to give information

In the event that I fail to provide the information, I consent and agree to allow the Company to withhold tax from any sum I am entitled to receive under the casualty insurance policy as stipulated in the FATCA.

If the Company exercises its right to withhold tax under the FATCA, in case I have failure to give information, the Company must send me a notice that I shall show any relevant documents or evidences or a letter to the Company, to confirm that I don't have a duty to pay taxes in U.S. within 30 days since receiving notice letter. If I fail to provide the information, the Company shall withhold tax from any sum I am entitled to receive under the casualty insurance policy as stipulated in the FATCA.

And the Company shall send the notice to the address given by me to the company.

Date..... Month.....Year.....

Signature.....

(.....)

Witness/Insurance agent/Insurance Broker

Signature.....

(.....)

Beneficiary (Juristic Person)

Director or Managing Partner, the Authorized Person of the Insured (Juristic Person) or Authorized Person

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