Insured Person or Premium Payer or Co-insured's Death Claim Document Required

Agent / Broker information required

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

Unit / Corporate Broker Name..... Branch..... Fax No.....

Policy Number..... Name of Insured /Co-insured.....

Name of Premium Payor.....

Agent/Agency Leader/Broker Signature..... Date DD/MM/YYYY.....

Dear Beneficiary

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

If death is due to natural cause (Illness)

- ☐ 1. Death claim form (Please fill out 1 form per 1 beneficiary)
- ☐ 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. A photo of the beneficiary's face with ID card*
- ☐ 9. Consent and Verification of Status for Compliance with the US Foreign Account Tax Compliance Act (FATCA Form) of all beneficiaries
- ☐ 10. Individual tax residency self-certification form of all beneficiaries
- ☐ 11. 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)
- ☐ 12. 3 Letters of Consent and Authorization with the signature of beneficiary
- ☐ 13. Others, please specify (Certificate of Name-Surname Change, Marriage Certificate, etc.).....

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

*If the beneficiary submits claim documents through an agent /broker / FWD branches or head office, no need to submit document No. 8 A photo of the beneficiary's face with ID card.

If death is due to an accident or unnatural causes 1-13 of the above specified documents, and please include the following.

- ☐ 14. 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
- ☐ 15. A certified true copy of the police report

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

- ☐ 16. 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 via email to OP_ClaimAdmin.th@fwd.com, through any FWD branches across the country, or send them directly to Claim Department, FWD Life Insurance Public Company Limited, Sindhorn Building Tower 3, 14th floor, 130-132 Wireless Road, Lumpini, Pathumwan, Bangkok 10330

Offcial use only

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

Insured Person or Premium Payer or Co-insured's Death Claim Form

FWD insurance

Please fill out 1 form per 1 beneficiary

1. Information of Deceased

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

Policy Number.....

2. Claimant

Full Name.....Age.....Years Nationality.....*Mobile Number.....email.....

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

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

Relationship to the deceased.....

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

3. Payment method for claim settlement

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

☐ Draft to be mailed directly to the address specified above.

* 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. 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

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

Name of Insurance Company	Policy Number	Date of Issue	Sum Insured

I hereby grant consent to FWD Life Insurance Public Company Limited (the "Company") to collect, use, and disclose my sensitive personal data. which I have provided in additional documents for the purpose to support all claims and benefit payments under policy contract including allowing the company to disclose personal data to its agents Brokers or service providers who are third parties to carry out the same purposes above. I have been informed and understood the purposes include information of company's privacy policy clearly as detailed in https://www.fwd.co.th/en/privacy-policy/

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

(.....)

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. Certifying status

A. Do you have nationality or country of birth related to the United States?

☐ No

☐ Yes, please specify

☐ U.S. Nationality, ☐ Born in USA, ☐ U.S. Nationality and Born in USA

B. Do you have or ever had U.S. Green Card or not?

☐ No

☐ Yes , Green Card No....., Expired Date.....

☐ Ever had and already expired, Green Card No..... , Expired Date.....

C. Do you have a duty to pay tax to the U.S. Internal Revenue Service or not?

☐ No

☐ Yes

D. Do you have a resident in USA for purpose of paying tax or not (e.g.having a resident in USA at least 183 days in the past calendar year)

☐ No

☐ Yes

2. Agreement

1. I acknowledge that **FWD Life Insurance Public Company Limited ("the Company")** is subject to and required to comply with FATCA.
2. I acknowledge that the Company has to collect, use,or disclose any of my information to the domestic or international government sectors to comply with FATCA.
3. I will provide additional information as request by the Company in order to comply with the FATCA in writing within the specified period.
4. I will notify the Company of any change in status or any information I have previously notified to the Company. If the status or information that changes is related to the United States within 30 days from the date of change of status or information.
5. In the event that I do not disclose the information under (3) and (4), I grant the Company the right to report my information to domestic or international government sectors to comply with FATCA.

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

Signature.....

(.....)

Witness / Insurance Agent

Signature.....

(.....)

Beneficiary

Signature.....

(.....)

☐ Father/Mother ☐ Legal representatives of the beneficiary

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. Certifying status

For Financial institution under the definition of FATCA with GIIN

GIIN Number	☐☐☐☐☐☐•☐☐☐☐☐•☐☐•☐☐☐
Country of incorporation or business operations	Entity registration number .....

1. I am 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.
   If you answer 'No', please answer No. 2 & No. 3
2. I am an entity that is a financial institution under the definition of FATCA
   ☐ No ☐ Yes
   Financial institution under the definition of FATCA such as 1. Depositary Corporations (bank, or similar like a bank) 2. Custodian Institute 3. Entity that conducting business related to investment (e.g. broker, investment manager and funds etc.) 4. Insurance company 5. The entity hold share in Financial institution under the definition of FATCA 6. Treasury center
3. I am an Entity 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
   Please answer 'No' if you are any No.1 or No.2 of the following
   1) A Governmental Entity that exempts from FATCA such as Government agencies, International Organization, or Central Bank of Issue.
   2) 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.
   If you answer 'Yes', please complete Form W-8BEN-E of the Internal Revenue Service (IRS) only.

2. Agreement

1) I (the entity) acknowledge that **FWD Life Insurance Public Company Limited ("the Company")** is subject to and required to comply with FATCA.
2) I (the entity) acknowledge that the Company has to collect, use, or disclose any of my information to the domestic or international government sectors to comply with FATCA.
3) I (the entity) will provide additional information as request by the Company in order to comply with the FATCA in writing within the specified period.
4) I (the entity) will notify the Company of any change in status or any information I have previously notified to the Company. If the status or information that changes is related to the United States within 30 days from the date of change of status or information.
5) In the event thatI (the entity) do not disclose the information under (3) and (4), I (the entity) grant the Company the right to report my information to domestic or international government sectors to comply with FATCA.

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

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

Individual tax residency self-certification form

Beneficiary Name and Surname.....**Policy No.**.....

☐ Identification No. ☐ Passport No.....Expire Date.....

Place of Birth City.....Country.....

Part 1 : Declaration of All Tax Residency (other than the U.S.)

Do you have tax residence in countries/jurisdictions other than the U.S.?

☐ Yes ☐ No

"tax residence"means particular jurisdictions in which you are liable to pay tax by reason of domicile, residence, or any other criterion. You must answer "Yes" if you have tax residence in countries/jurisdictions other than the U.S.and specify your country/jurisdictions of tax residence and TIN in the table below. If you select "No" end the question.

Country/Jurisdiction of Tax Residence	TIN	If no TIN available, enter Reason A, B or C	Please explain why you are unable to obtain a TIN if you select Reason B

If a TIN is unavailable, indicate which of the following reason is applicable:

Reason (A) – The jurisdiction where the beneficiary is a tax resident does not issue TINs to its residents.

Reason (B) – The beneficiary is otherwise unable to obtain a TIN.(Note: Please explain why you are unable to obtain a TIN.)

Reason (C) – TIN is not required. (Note: Only select this reason only if the domestic law of the relevant jurisdiction does not require the collection of TIN issued by such jurisdiction.)

Part 2 : Confirmation, Change of status and Disclosure of information

1. I confirm that the above information is true, correct, accurate and complete.
2. I acknowledge that the Life Insurance Company ("the Company") is subject to and required to comply with the Emergency Decree on Exchange of Information for International Tax Compliance (CRS).
3. I acknowledge that the Company has to collect, use, or disclose any of my information to the domestic or international government sectors to comply with the CRS.
4. I will provide additional information as request by the Company in order to comply with the CRS in writing within the specified period.
5. I will notify the Company of any change in status or any information I have previously notified to the Company. If the status or information that changes is related to tax residency within 30 days from the date of change of status or information.
6. In the event that I do not disclose the information under (4) and (5), I grant the Company the right to report my information to domestic or international government sectors to comply with CRS.

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

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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