

### DEATH CLAIM FORM

For Maybank Use Only. Compulsory to fill up or application will be incomplete.

Financing Type: ☐ ASB ☐ Mortgage / Others

Financing Status: ☐ Full Settlement ☐ Outstanding

Full Settlement Date: \_\_\_\_\_

### SECTION A

Section A of this form is to be completed by the claimant who is legally entitled to contract money. Every question must be fully answered. The Company reserves the right to require further information should it deem necessary. Submission of this Claim Form does not guarantee admission of liability.

Contract No \_\_\_\_\_

Agent's name & code: \_\_\_\_\_

Agent's Contact No: \_\_\_\_\_

#### Instruction – Supporting documents required

- ☐ Death claim form
- ☐ Death Statement of Medical Examiner (for contract duration < 5 years)
- ☐ Certified copy of Participant and Claimant's IC
- ☐ Certified copy of Death Certificate
- ☐ Certified copy of Burial Certificate
- ☐ Original certificate/policy contract
- ☐ Certified copy of proof of relationship between claimant and participant
- ☐ Certified copy Sijil Faraid / Letter of Administration (if applicable)

#### Additional requirements on accidental death

- ☐ Detailed Post Mortem report
- ☐ Certified copy of Toxicology report, if any
- ☐ Certified copy of police report
- ☐ Newspaper Cutting, if any

#### Additional requirements for death in overseas

- ☐ Confirmation letter from National Registration Department (JPN)
- ☐ All relevant documents issued by Foreign Authority must be certified by Malaysia Embassy or Public Notary

#### DETAILS OF PARTICIPANT

Name of Participant in full \_\_\_\_\_

New IC No \_\_\_\_\_ Old IC No. \_\_\_\_\_ Age \_\_\_\_\_

Last Address of Participant \_\_\_\_\_

\_\_\_\_\_

Name of the Employer of Participant at the time of death \_\_\_\_\_

Address of the Employer \_\_\_\_\_

\_\_\_\_\_

Date of Employment \_\_\_\_\_ (dd/mm/yyyy) Office Phone No. \_\_\_\_\_

What family has the Participant left? ☐ Spouse ☐ No. of Child \_\_\_\_\_ ☐ Parent ☐ Others, please specify \_\_\_\_\_

**DETAILS OF CLAIMANT**

Name of Claimant: \_\_\_\_\_

New IC No: \_\_\_\_\_ Old IC No: \_\_\_\_\_ Age: \_\_\_\_\_

Correspondence Address: \_\_\_\_\_  
\_\_\_\_\_

Mobile Phone No.: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

What is your relationship with the Participant? \_\_\_\_\_

Please state your bank account details in order for us to credit the payment directly into your bank account.

Bank: \_\_\_\_\_ Account No: \_\_\_\_\_

1. Date of death: \_\_\_\_\_ (dd/mm/yyyy) Time: \_\_\_\_\_ (am/pm)
2. Cause of death: \_\_\_\_\_
3. Place of death: \_\_\_\_\_
4. When did Participant **first** complain of or give indication of his / her last illness? \_\_\_\_\_ (dd/mm/yyyy)
5. When did Participant **first** consult a Physician for his / her last illness? \_\_\_\_\_ (dd/mm/yyyy)
6. Name & address of doctor Participant **first** consulted for his / her last illness \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Please state names and address of every physician who attended the Participant during his / her last illness

Date of consultation (dd/mm/yyyy)	Date of admission (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Diagnosis	Name of doctor & address of hospital/clinics

8. State the name and address of Participant's regular doctor \_\_\_\_\_  
\_\_\_\_\_

9. Are there other certificates in force on Participant covered by other companies? ☐ Yes ☐ No

If yes, please give details:

Name of Company(s)	Commencement date (dd/mm/yyyy)	Contract No (dd/mm/yyyy)	Type of Coverage	Sum covered

10 Death due to accident

- a. Date of accident: \_\_\_\_\_ (dd/mm/yyyy) Time : \_\_\_\_\_ (am/pm)
- b. Place of accident : \_\_\_\_\_
- c. Why was the Participant at the location ? \_\_\_\_\_
- d. Describe in detail how the Accident happened ? \_\_\_\_\_
- e. Was the accident reported to the police? ☐ Yes ☐ No (If yes, please submit a certified copy of police report)
- f. Was the accident reported in the newspaper? ☐ Yes ☐ No (If yes, please submit a copy)
- g. Was an inquest or post-mortem carried out? ☐ Yes ☐ No (If yes, please submit a certified copy of post mortem report)

**DECLARATION**

I/We hereby declare that the foregoing answers and statements are complete and true to the best of my/our knowledge and belief, and that I/we have withheld no material facts from the Company.

\_\_\_\_\_  
Signature of Claimant

Full name \_\_\_\_\_

Contact No \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness

Full Name \_\_\_\_\_

NRIC No \_\_\_\_\_

Contact No \_\_\_\_\_

Date \_\_\_\_\_



**LETTER OF AUTHORISATION / CONSENT  
TO OBTAIN FURTHER INFORMATION (DEATH CLAIM)**

To Whom It May Concern,

Dear Sir / Madam,

I hereby authorize and give my consent to any medical practitioner, physician, surgeon, clinic, hospital, medical centre, Insurance company or other organization, institution or individual concerned ("the Information Provider(s)") that may have any records or knowledge of the employment, financial, health or medical history of \_\_\_\_\_ (name of Participant) and to provide such information to Etiqa Family Takaful Berhad or its authorized agents and / or employees.

I expressly waive on behalf of myself and / or as a next-of-kin of the Participant and for his / her estate all provisions of law or professional ethics forbidding the Information or (Providers) from disclosing any such information acquired on the Participant in a professional and / or client capacity and I further release the Information Provider(s) and its agent / staff from any liability whatsoever that may arise, in supplying such information requested by the Company.

This authorization / consent is irrevocable and a copy of it will have the same effect and validity as the original.

\_\_\_\_\_  
Signature / Thumb print of Next-of-Kin / Claimant

Name : \_\_\_\_\_

NRIC: \_\_\_\_\_

Old IC: \_\_\_\_\_

Relationship with Participant: \_\_\_\_\_

Contact No: \_\_\_\_\_

Date: \_\_\_\_\_