

### Transamerica Life (Bermuda) Ltd.

(Incorporated in Bermuda with limited liability)

Select the box that applies

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# **CLAIM FORM**

### **IMPORTANT INFORMATION**

Please complete in ENGLISH and BLOCK CAPITALS.

If you make a mistake completing this form, simply cross out the error, note the correct details and initial each correction.

In order for your claim to be processed as quickly as possible, we need some information about the claimant and the insured. Prior to completing this statement, please read the instructions on the back of this form. If there is more than one claimant, each claimant must complete a separate Claim Form.

The policy of insurance is issued or assumed by Transamerica Life (Bermuda) Ltd. ("TLB").

Please attach one original/ notarized death certificate for each insured.

### A. Information about the Insured

Policy number(s) under which you are presenting a claim				
Insured's Name				
Alias Name (if any)	(1) (2)			
ID Number	Image: NRIC       Type       Image: Other			
	Number/Street/Building			
Address				
Autress	City		Province	
	Country		Postal Code	
Date of Birth	(dd/mm/yyyy)			
Date of Death	(dd/mm/yyyy)			
Cause of Death				
Place of Death				

# B. Complete this section only if the policy was issued or reinstated within two years of the date of death. Also, please return the policy, if possible.

When did the insured first complain of or give other indications of last illness?				
When did the insured	first consult a physician for last illness?			
Names of all physicia	as or practitioners who attended the insured within	5 years preceding death (attach additional sheet if pecessary)		
Names of all physicial	ns or practitioners who attended the insured withir	5 years preceding death (attach additional sheet if necessary).		
Names of all physicial	ns or practitioners who attended the insured within Address	5 years preceding death (attach additional sheet if necessary).           Date of Attendance         Condition(s)		
		Date of Attendance Condition(s)		
		Date of Attendance Condition(s)		
		Date of Attendance Condition(s)		
		Date of Attendance Condition(s)		

# C. Information about the Beneficiary/ Claimant

Name	Given Name(s)	Surname				
Alias Name (if any)	(1)	(2)				
Date of Birth	(dd/mm/yyyy)	Nationality				
ID Number	Type NRIC Passport Business Registration					
Relationship to the Insured						
	Number/Street/Building	Number/Street/Building				
Residential Address						
	City	Province				
	Country	Postal Code				
	Number/Street/Building					
Correspondence Address (If different from	3S					
residential address)	City	Province				
	Country Postal Code					
Phone Number	Country Code Area Code Phone Number					
Occupation Title		Occupation Industry				

TLB 1178SGE CF 0325

Select the box that applies

D. Other Life Insurance Coverage Details			Select the box that applies			
Insurance Company Name	Policy Number	lssue Year	Life Insurance Amount (USD)	Claim Status		
Insurance Company Name				Paid	Pending	Declined
*If more than three other insurance coverage details, please provide details in the "Supplementary Information Section".						

# E. Payment Instruction

I/We, hereby, authorise TLB to arrange proce	eeds as follows (If no option is selected, proceeds will be	paid by cheque to beneficiary):
Payment Method	By cheque (applicable to amount less than USD500,000 or equivalent. For USD cheque, a local clearing USD cheque will be issued.)	<ul> <li>By Telegraphic Transfer</li> <li>(Please complete below Telegraphic Transfer Details Section.)</li> </ul>

# F. Telegraphic Transfer Details

Correspondent Bank Information (if applicable)			
Correspondent Bank Name			
Correspondent Bank Swift Code			
Correspondent Bank Address			
Beneficiary Bank Information			
Beneficiary Account Holder Name			
Beneficiary Account Number			
Beneficiary Swift Code			
Beneficiary Bank Name			
Beneficiary Bank Address			
Note: Payment must be made to beneficiary/claimant only.			

Select the box that applies

### **Declaration, Consent and Authorisation**

#### I, THE BENEFICIARY/ CLAIMANT, HEREBY:

Consent and Authorise:

- a) any registered medical physician, medical practitioner, medical care provider, hospital, clinic, medical laboratory, government organisation or any other medical or medical related facility that has record or knowledge of the insured's health and medical history or treatments to provide such information about the insured (including diagnosis, examination and test results, medical reports, treatments and prognosis) with respect to any of the insured's physical or mental conditions and/or treatments to TLB (or its legal representatives); and
- b) TLB to disclose such medical or other information about the insured which has been provided to TLB or which TLB develops during its evaluation of any application or claim for life insurance to: (i) its reinsurers; (ii) any other insurance company that the insured may designate; (iii) any financial adviser representative that the insured may have designated; (iv) any medical professional that the insured may have designated; and (v) any person or entity entitled to receive such information by law.

### **Personal Information Collection Statement**

Transamerica Life (Bermuda) Ltd. ("TLB") is committed to complying with the Personal Data Protection Act 2012 ("PDPA") and any other applicable laws and regulations in relation to the collection, use, disclosure, transfer, retention and storage of your personal data.

Please read the Privacy Policy before you complete this form. The Privacy Policy is available on TLB's website (https://www.transamericalifebermuda.com/en/privacy-policy/) or can be requested in hardcopy from your broker. By completing and returning this form to TLB, you are confirming that you have obtained a copy of, read and understood the Privacy Policy and consent to the use, disclosure and processing of your personal data in accordance with and agree to be bound by the Privacy Policy.

The claimant understands that TLB may not have verified the status of the life insurance policy. The claimant agrees that by furnishing this form, TLB does not admit that any insurance was in force on the life of the deceased and does not waive any of its rights of defenses.

# **Fraud Warning**

Any person who knowingly presents a false or fraudulent claim of a loss or benefit may be guilty of a crime and may be subject to fines and/ or confinement in prison.

# Declaration by Beneficiary/ Claimant

Select the box that applies

I/We agree that payment made to me/us pursuant to this claim in the manner as directed above fully and finally satisfies and discharges TLB's payment obligations to me/us under the policy and no further claim will be made by me/us under the policy.				
Signature of Bene	ficiary/ Claimant			
Signed at	(Country)	Date	(dd/mm/yyyy)	
Name				
Signature (include Ti	itle, if Corporation or Trust)		x	
Signed at	(Country)	Date	(dd/mm/yyyy)	
Name				
	ID Number		Signature	
Type NRIC Passport Other			x	
Address				

The cost, if any, of completing claim requirements, is to be borne by the beneficiary or claimant.

## **Documentary Requirement Checklist**

process your claim if necess	ary. W	ted below are for your reference only. We reserve the right to request additional information or documents to fe may not be able to process your request or your claim payment may be delayed if the required documents ust be original or certified copies unless otherwise specified.
		Document Required (Please "✓" against the documents you have submitted)
		Original/ notarized death certificate *For a death certificate issued by the Singapore government, we will accept the digital copy(ies)
		Identity document of insured
		Completed "Claim Form"
Basic Document		Completed "Self-Certificate Form (Individual)" or "Self-Certification Form (Entity and Controlling Persons)"
		Policy contract (if available)
		Completed "Overseas Death Questionnaire Form" (if the death occurred outside the country of residence of the insured)
		Autopsy report, police report & newspaper cuttings (if the death was due to accident or unnatural cause.)
Beneficiary as Individual		Completed "Form W-8Ben"- required if beneficiary has U.S. indicia but not declared as U.S. tax resident status
Denenciary as multidual		Copy of proof of relationship between beneficiary and insured (e.g. Spouse - Marriage Certificate)
		Identity document and address proof (within 3 months validity) of beneficiary
		Certificate of Incorporation
		Company search undertaken within the last 3 months or copy of the certificate of incumbency (issued within 6 months of the application)
		Articles of Association
		Updated Authorized Signatory List and Board Resolution approving the Signatory List and the signor(s) to operate the policy for claims matter
		Identity document of Person(s) with Executive Authority, if applicable
		Identity document and address proof (within 3 months validity) of Director(s)
Beneficiary as an		Identity document and address proof (within 3 months validity) of Authorized Signor(s)
ENTITY		Identity document and address proof (within 3 months validity) of Shareholder(s)/ Ultimate Beneficiary Owner(s)
	Addit	ional documents for ENTITY with trust structure
		Completed "Verification of Trust Agreement For Administration of Life Insurance Policy Form"
		Trust Deed (with information on Settlor(s), Trustees, Protector(s) (if any), Trust Beneficiary(ies), Name and Date of Trust and Execution page with Settlor(s) and Trustees' signature
		Identity document and address proof (within 3 months validity) of Trustee(s)
		Identity document and address proof (within 3 months validity) of Settlor(s) (if any)
		Identity document and address proof (within 3 months validity) of Protector(s) (if any)
		Identity document and address proof (within 3 months validity) of beneficiary(ies) mentioned in Trust (if any)
Beneficiary as Estate/		Letter of Probate/ The Grant of Letters of Administration
Intestate		Identity document and address proof (within 3 months validity) of Administrator/Executor
Beneficiary as Minor/		Legal Guardianship paper
Mentally Incompetent Person		Identity document and address proof (within 3 months validity) of the Guardian
		Original/ notarized death certificate of the designated beneficiary
Deceased Beneficiary		Copy of proof of relationship between deceased beneficiary and insured (e.g. Spouse - Marriage certificate)

Suitable certifier may include (a) a practising advocate, solicitor or foreign lawyer as defined in the Legal Profession Act (Chapter 161); (b) a member of the judiciary in a Financial Action Task Force member country; (c) an officer of an embassy, consulate or high commission of the country of issue of documentary verification of identity; (d) a Magistrate, Justice of the Peace, or Commissioner for Oaths appointed in Singapore or in an equivalent jurisdiction; (e) your financial adviser representative; (f) a notary public; or (g) government authorities of Singapore if required. Alternatively, you may visit our office at the above address and submit these documents in person. Any original document(s) will be returned as soon as possible after our review.