Klook Accident Cover (underwritten by FWD Singapore) Insurance Claim Form

Important notes

1. In order for us to process your claim, please complete this claim form in full and submit with the relevant documents based on the type of claim you're submitting by email to lifeclaims.sg@fwd.com
2. All questions in this claim form must be fully and truthfully answered. Please note that we reserve our rights to cancel the coverage if any information provided in this claim form is made knowingly by you that it is materially false or misleading.
3. We reserve the right to request the authentication of documents that are not issued in Singapore by either i) the Singapore embassy in the country of death, ii) Singapore Consulate or iii) a Notary Public, if necessary.
4. All documents submitted must be in English. Any document that is not in English must be accompanied by an English translated copy of the document made by a certified translator/interpreter.
5. We reserve the right to request for further information, reports or documents that are necessary to assess your claim. Do note that the cost of obtaining any information, reports or documents will be borne by the claimant.
6. The acceptance of this form is NOT an admission of liability on the part of FWD Singapore Pte. Ltd.

Documents Required

Please provide these documents for Accidental Death claim

1. This completed claim form

   [Please note that the death claim form is to be completed by the next of kin or proper claimant]
2. Death Claim (Doctor's Statement) – Please refer to https://www.fwd.com.sg/forms/#claims/
3. Consent form
4. Death certificate (certified true copy)
5. Coroner's inquest report
6. Post-mortem report and toxicology report (if any)
7. A copy of police report and/or police investigation result (if any)
8. Copies of all medical reports, including doctor's memo, laboratory test results, diagnostic report and/or relevant medical reports that are available
9. Letter from ICA (Immigration & Checkpoint Authority) for a Singaporean or Permanent Resident (PR) who died overseas confirming the invalidation of the deceased's Singapore NRIC/Passport and overseas death certificate
10. Copy of Klook voucher/booking confirmation
11. Proof of participation in Klook activity/entrance or event ticket/reservation details
12. NRIC/FIN/Passport of the claimant (certified true copy)
13. Copy of the NRIC/FIN/Passport of the deceased
14. Proof of relationship of claimant with deceased (e.g. For spouse, please provide marriage certificate of claimant or for children, please provide birth certificate of claimant)
15. Certified true copy of the last Will and testament of the deceased/Grant of Letters of Administration/Probate
16. Copy of bank passbook/statement stating name of bank, name of bank account holder(s) & bank account number must be provided if the selected payment method is direct credit or telegraphic fund transfer
17. FATCA and CRS self-certification form

Please provide these documents for Total and Permanent Disability (TPD) claim due to accident

(A waiting period of 6 consecutive calendar months from date of disability must elapse before a disability claim will be considered)

1. This completed claim form
2. Disability or Terminal Illness Claim (Doctor's Statement) – Please refer to https://www.fwd.com.sg/forms/#claims/
3. Consent form
4. A copy of police report and/or police investigation result (if any)
5. Copies of all medical reports, including doctor's memo, laboratory test results, diagnostic report and/or relevant medical reports that are available
6. Copy of Klook voucher/booking confirmation
7. Proof of participation in Klook activity/entrance or event ticket/reservation details
8. Copy of the NRIC/FIN/Passport of life assured
9. NRIC/FIN/Passport of the claimant (certified true copy) if different person from life assured
10. Proof of relationship of claimant with life assured (e.g. For spouse, please provide marriage certificate of claimant or for children, please provide birth certificate of claimant)
11. Copy of bank passbook/statement stating name of bank, name of bank account holder(s) & bank account number must be provided if the selected payment method is direct credit or telegraphic fund transfer
12. FATCA and CRS self-certification form

Please provide these documents for Medical Expense claim due to accident

1. This completed claim form
2. Consent form
3. A copy of police report and/or police investigation result (if any)
4. Copies of all medical reports, including doctor's memo, laboratory test results, diagnostic report and/or relevant medical reports that are available
5. A copy of inpatient discharge summary (if applicable)
6. A copy of doctor's memo and/or relevant medical reports, diagnostics and laboratory reports
7. Medical bill(s)/Invoices
8. Copy of Klook voucher or booking confirmation
9. Proof of participation in Klook activity/entrance or event ticket/reservation details
10. NRIC/FIN/Passport of the claimant (certified true copy)
11. Copy of bank passbook/statement stating name of bank, name of bank account holder(s) & bank account number must be provided if the selected payment method is direct credit or telegraphic fund transfer

Please provide these documents for Daily Hospital Cash due to accident

1. This completed claim form
2. Consent form
3. A copy of police report and/or police investigation result (if any)
4. A copy of inpatient discharge summary
5. Copies of all medical reports, including doctor's memo, laboratory test results, diagnostic report and/or relevant medical reports that are available
6. Medical bill(s)/Invoices
7. Copy of Klook voucher or booking confirmation
8. Proof of participation in Klook activity/entrance or event ticket/reservation details
9. NRIC/FIN/Passport of the claimant (certified true copy)
10. Copy of bank passbook/statement stating name of bank, name of bank account holder(s) & bank account number must be provided if the selected payment method is direct credit or telegraphic fund transfer

Section 1: Personal details of claimant

Full name (as in NRIC/FIN/Passport)	
NRIC/FIN/Passport number	
Nationality	
Country of Residence	
Email address	
Contact/Mobile number	
Address	

Section 2: Claims details

Type of claims
(please tick whichever applicable)

- ☐ Accidental Death
- ☐ Total and Permanent Disability
- ☐ Medical Expenses
- ☐ Daily Hospital Cash

Klook activity details

COI reference number
(please refer to email from FWD/your policy documents)

Activity Name

Participation start date

Participation end date

Accident details

Date of accident

Time of accident (HH:MM)

Place and Country of accident

Circumstances of accident

Nature and extent of injury

Was the accident reported to the event organizer or service provider? ☐ Yes ☐ No
If "yes", please provide the following details

Date of report

Name of staff who attended to the report

Contact no./ email address of staff

(If a copy of the report is available, please submit a copy to us)

Was there any eye-witness to the accident? ☐ Yes ☐ No
If "yes", please provide the name and contact details of the witness

Name of witness	
Contact no/ Email address of witness	

Diagnosis/treatment details

Date of 1st medical consultation sought	
Diagnosis	
Date of diagnosis	
Name of attending doctor/specialist & address of hospital/clinic	
Details of treatment provided	
Date of admission	
Date of discharge	

Please complete the following section if you are claiming for **Accidental Death**

Name of deceased (as shown in NRIC/FIN/Passport)	
NRIC/FIN/Passport number	

Nationality	
Country of residence	
Date of death	
Place and Country of death (please specify hospital name if death occurred in hospital)	
Cause of death	
Marital status at point of death	

Who are the surviving family members of the deceased?

- ☐ spouse
- ☐ children
- ☐ parents
- ☐ siblings

Name	NRIC/FIN/Passport number	Relationship	Age

Did the deceased leave a will? ☐ Yes ☐ No

If 'Yes', please provide us with a copy of the last will and the executor's particulars.

Please complete the following section if you are claiming for **Total and Permanent Disability**

Name of insured member
(as shown in NRIC/FIN/Passport)

NRIC/FIN/Passport number

Nationality

Country of residence

Date of disability started

Type of Disability:

- ☐ Totally and Permanently Disabled
- ☐ Permanent and Total Loss of Sight in Both Eyes
- ☐ Permanent and Total Loss of Speech and Permanent & Total Loss of Hearing
- ☐ Permanent and Total Loss of Use of 2 or More Limbs.

Has the insured member previously suffered from, or received treatment for a similar or related disability?
If "yes", please provide details:

☐ Yes ☐ No

Is the insured member currently confined to bed/house/hospital/other?
Please provide name of hospital:

☐ Yes ☐ No

List of activities of daily living the insured member is unable to perform totally and permanently due to this disability:

Section 3: Other information

Any other insurance policy owned by the deceased or the insured member?

Name of other insurance company(ies)/type of plan/date of issue/sum assured

Are there any claims submitted or to be submitted to any other insurance company(ies) in respect of this claim? If yes, please provide details ☐ Yes ☐ No

Has the deceased or the insured member or claimant been made bankrupt or insolvent or executed any deed or transfer for the benefit of creditors since becoming interested in the policy? ☐ Yes ☐ No

Section 4: Mode of payment

Once approved, your claim amount will be credited into your bank account. Kindly provide your bank account details.

☐ Bank transfer

Name of Bank

Account holder's name(s)

Bank Account number

If you would like the settlement amount by cheque, please fill in the following:

Payee name

Mailing address

Declaration, authorisation and consent to use personal data

1. I certify that the information provided in this form is true and complete and I have not withheld any material information that could affect this claim.

2. For the purposes of policy administration, which includes the processing and/or investigation of this claim, I hereby:
   a. authorise any person or organisation who has relevant information on this claim, including but not limited to any medical practitioner, health care provider, clinic, hospital, insurance company and/or investigative agency, to release and exchange any and all information (including personal health information) requested by FWD Singapore Pte. Ltd. and/or its claims service providers;
   b. authorize FWD Singapore Pte. Ltd. and/or its claim service providers to collect, use, disclose and/or exchange with such persons or organisations referred to in above any and all relevant information (including personal health information); and
   c. confirm that I am authorized to disclose information (including personal health information) about the insured member if this claim is made on his/her behalf.

3. I confirm that I will produce all original bills/invoices/receipts that were submitted for reimbursement to FWD Singapore Pte. Ltd. upon request, for verification.

4. I confirm that I have not claimed and do not intend to claim or obtain reimbursement from any other insurer/company. If I received full reimbursement of medical expenses from any other insurance policy for the same claim, I agree to withdraw my claim or I will not receive payout from FWD Singapore Pte Ltd. In the event my claim has been paid out by FWD Singapore Pte Ltd, I will provide the copy of the settlement letter to FWD Singapore Pte Ltd and I will refund FWD Singapore Pte Ltd any excess amount paid to me as a result of the reimbursement.

5. I agree to indemnify FWD Singapore Pte Ltd for any and all liabilities, claims, demands, action and cause of action whatsoever arising out of or in relation to any losses, damages, demands, action or cause of action FWD Singapore Pte Ltd incurs as a result of this claim, and acknowledge that FWD Singapore Pte Ltd shall recover any payment(s) made to you or the insured member pursuant to this claim in the event that such payment was made based on any untrue, incomplete or inaccurate information.

6. I also give consent for FWD Singapore Pte. Ltd. to collect, use or disclose my personal data for audit, business analysis, reinsurance purposes and for the purposes set out in FWD's Privacy Policy, which can be found at www.fwd.com.sg

7. I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

8. My signature below will signify my consent.

Signature of Claimant

Signed and declared on
(dd/mm/yyyy)

Name of Claimant

Relationship with insured member

Consent form

1. To

2. Address

3. Name of Insured

4. NRIC/FIN

Declaration & authorisation

1. For the purposes of policy administration, which includes the processing and/or investigation of this claim, I hereby:
   a. authorise any person or organisation who has relevant information on the above insured and/or this claim, including but not limited to any medical practitioner, health care provider, clinic, hospital, insurance company and/or investigative agency, to release and exchange any and all information (including personal health information) requested by FWD Singapore and/or its claims service providers;
   b. authorize FWD Singapore and/or its claim service providers to collect, use, disclose and/or exchange with such persons or organisations referred to in (a) above any and all relevant information (including personal health information); and
   c. confirm that I am authorized to disclose information (including personal health information) about the life assured if this claim is made on his/her/their behalf.

2. I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

3. My signature below will signify this consent.

Signature of insured/next-of-kin of deceased insured/insured's parent or legal guardian (if Insured is below 21 years of age)

Name of Claimant

Relationship with policyholder/insured

NRIC/FIN/Passport

Date