CHUBB®

Home Payment Care
Claim Form

SG020

Policy No.: _____

Section A: Particulars of Policyholder/Insured Person/Claimant

Name of Policyholder: DBS Bank Ltd

Name of Insured Person (As shown in NRIC/Passport): _____

_____

NRIC/Passport No.: _____ Nationality: _____ Gender: ☐ Male ☐ Female Date of Birth: DD / MM / YYYY

Mailing Address of Insured Person: _____

_____ Postal Code: _____

Tel No. (Mobile): _____ Occupation: _____

Email: _____

Name of Claimant (As shown in NRIC/Passport) - If different from Insured Person: _____

_____

NRIC/Passport No.: _____ Nationality: _____ Gender: ☐ Male ☐ Female Date of Birth: DD / MM / YYYY

Mailing Address of Claimant: _____

_____ Postal Code: _____

Tel No. (Mobile): _____ Occupation: _____

Email: _____

Section B: Payment of Claims

Any benefits payable under this Policy shall be paid to the Policyholder and/or the Insured Person or his estate in accordance with this Policy.

Section C: Involuntary Loss of Employment Benefit

Name of Employer: _____

Date of Employment: DD / MM / YYYY Date of Retrenchment/Business cease (Bankruptcy): DD / MM / YYYY

Employment Type: ☐ Permanent ☐ Contract ☐ Temporary ☐ Self-Employed

Reason for Retrenchment/Termination _____

Section D: Accidental Death/Accidental Permanent Disability Benefit
(Please enclose a copy of police report if accident is due to road traffic accident)

Date of Accident: DD / MM / YYYY Time of the Accident (24-Hour): HH : MM

Country of Accident: _____ Place of Accident: _____

Chronology and description of the accident/loss and detail the injuries sustained (Please use supplementary sheet if necessary)

_____

_____

_____

_____

_____

Has the insured person previously suffered this or a similar condition or a recurrence of a previous injury? ☐ Yes ☐ No

If **Yes**, please give details: _____

Was the insured person under the influence of alcohol, medication, drugs or any other intoxicating substance at the time of accident? ☐ Yes ☐ No

If **Yes**, please provide details of name/type of alcohol, medication, drugs or intoxicating substances.

_____

_____

Details of Hospitalisation (If applicable - please attach In-Patient Discharge Summary)

Name of Hospital: _____

Period of Hospitalisation: From DD / MM / YYYY To DD / MM / YYYY

Was the insured person referred by a General Practitioner/Specialist/other Hospital? ☐ Yes ☐ No

If **Yes**, please provide the name of the General Practitioner/Specialist/Hospital: _____

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Section E: Declaration

Did you remember to enclose the following? (Where applicable)

Document	Yes	N/A
Retrenchment/Termination letter from the relevant person or department within the insured person's employer stating employment details	☐	☐
A copy of the insured person's CPF Contribution History Statement for the period of unemployment	☐	☐
Bankruptcy Order and any other documentary evidence required by us for the insured persons who are self-employed	☐	☐
Traffic Police report (If involved in a road accident)	☐	☐
Driving license (If the insured person was driving at the time of accident)	☐	☐
Written notes from Physician on type of injury sustained/Inpatient Discharge Summary or Medical Report	☐	☐
Death certificate and letters of administration/probate (If applicable)	☐	☐
Autopsy and Toxicology report	☐	☐
Coroner's Inquiry report; Police Investigation reports and findings on the alleged accident; and Incident Report lodged by the employer (If applicable)	☐	☐

By signing this form, I/We agree that Chubb will use the information supplied here and during the formation and performance of my policy, for policy administration, customer services, claims handling and fraud analysis and prevention, and that Chubb may disclose such information to its service providers, agents, authorities and other parties for these purposes.

I/We hereby authorise any hospital, physician, and any other person or entity who has attended to or examined me, to furnish to Chubb or its authorised representatives, any and all information with respect to any illness or injury or loss, medical history, consultation, prescriptions or treatment, copies of all hospital, medical or other records, investigation status and results, and such personal information as Chubb in its absolute discretion considers relevant for its assessment of my claim. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

I/We do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I/We agree that if I/We have made or in any further declaration or representation shall make any false or fraudulent statements or suppress, conceal or falsely state any fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past, present or future claims shall be forfeited.

_____	_____	_____
Name of Insured Person	Signature of Insured Person	Date
_____	_____	_____
Name of Claimant (If different from Insured Person)	Signature of Claimant (If different from Insured Person)	Date

Contact Us

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Chubb. Insured.™

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