LIFE INSURANCE DEATH CLAIM FORM

Please check all details, then complete the relevant areas of the form and return it to:
BSP Life PNG Limited, Level 2 Waigani Banking Centre | Section 34, Allotment 6 & 7, Klinki Street,
Waigani Drive | P O Box 78, Port Moresby, National Capital District, Papua New Guinea
Telephone: (675) 305 6214 Email: servicebsplife@bsp.com.pg

PLEASE COMPLETE ALL DETAILS IN BLOCK LETTERS

1. POLICY DETAILS

Policy Number | Policy Commencement Date

2. DETAILS OF THE DECEASED

First Name | Middle Name | Surname

Mr/Mrs/Miss/Ms

Date of Birth | Date of Death | Place of Death

Medical Attendant who certified the death

Cause of death

(i) List all [1]Medical Providers consulted for any condition in the past five (5) Years.

Name	Address	Dates Consulted

(ii) List all hospital admissions in the past five (5) years.

Name	Address	From	To	Reasons for Confinement

3. SUPPLEMENTARY REQUIREMENTS *(Please ensure all requirement are attached to this form)*

- ☐ Certified copy of Death Certificate stating cause of Death
- ☐ Certified copy of Birth Certificate of Deceased.
- ☐ Marriage Certificate *(if applicable).*
- ☐ Medical Reports.
- ☐ Police Report *(if death was caused accidentally).*
- ☐ Original Policy Document.
- ☐ Identification details of the beneficiary for CDD.

4. DETAILS OF THE BENEFICIARY or POLICY OWNER

First Name | Middle Name | Surname

Mr/Mrs/Miss/Ms

Date of Birth | Relationship to Deceased

Postal Address

Email Address

[1] *Medical Provider means either a Doctor, Physician, General Practitioner, Medical Attendant, Specialist, Clinic or Hospital.*

Bank Details:

Name of Account		Bank	
Account Number		Branch	

Beneficiary Identification Details: *(Complete the following for verification of identity. Identification must meet a combined value of 40 points or more)*

Type	Number	Expiry Date

5. DECLARATION AND AUTHORISATION: (To be completed by the Beneficiary or Policy Owner)

(a) **I declare** to the best of my knowledge that the information provided in this form is true, correct and complete.

(b) **I understand** that BSP Life PNG Limited (BSP Life) will use the information provided in this form for the purpose of evaluating a claim for Life Insurance benefits.

(c) **I authorise** BSP Life to obtain from any person or organisation, personal or medical information required to evaluate this claim, and **I authorise** the person or organisation to disclose such information to BSP Life. This includes information held by any Medical Provider, allied health service**,** insurer, or other relevant entity or organisation.

(d) **I agree** that a photocopy of this authority will be used as verification to obtain relevant information for the purpose of this claim.

Beneficiary or Policy Owner:

Signature	Signed at:
	Date:

Witness:

Signature	Signed at:
	Date:
Full Name of Witness:	

Please return this form with all requirements to:

Benefits Management
BSP Life PNG Limited
Level 2 Waigani Banking Centre
Section 34, Allotment 6 & 7 Klinki Street
Waigani Drive
Port Moresby
National Capital District
PAPUA NEW GUINEA

Or, Post to:

Benefits Management
BSP Life PNG Limited
P O Box 78
Port Moresby
National Capital District
PAPUA NEW GUINEA