Group Term Life Insurance 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) 3056214 Email: servicebsplife@bsp.com.pg

PLEASE READ THESE NOTES

- For Death Claim, please complete Section D.
- For Accidental Total and Permanent Disability Claim, please complete Section E.
- For Personal Accident Claim, please complete Section F.
- The Medical Provider Statement must be completed for Accidental Total and Permanent Disability and Personal Accident Claims and to be returned to BSP Life at the address above.

Account Manager: **Policy Number**

SECTION A. TYPE OF CLAIM

1. Please tick the appropriate claim type below and complete the sections relevant to the Claim.

☐ Death ☐ Accidental Total and Permanent Disability ☐ Personal Accident Scale _____

For any **Accidental Total and Permanent Disability (TPD)** and **Personal Accident (PA)** Claim, your Medical Provider must complete the Medical Provider's Statement on Page 5 and post it directly to BSP Life at the address above or call BSP Life to uplift the document.

SECTION B. DETAILS OF LIFE INSURED

Personal Details

Title:	First Name:	Middle Name(s):
Last Name:		Date of Birth:

Gender: ☐ Male ☐ Female

SECTION C. DETAILS OF POLICY OWNER

Organisation Details

Full Name:
Name of Authorised Representative:
Designation:

Contact Details

Work Telephone	Direct Office Telephone
Mobile	Facsimile
Email	

SECTION D. DEATH CLAIM

Date of Death		Place of Death	
[1]Medical Provider who certified Death			
Cause of Death			

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

1. List all Medical Providers consulted for any condition related to the cause of death in the past five (5) years.

Name of Medical Provider	Address	Date Consulted.

2. List all Hospital confinements in the past five (5) years.

Name	Address	From	To	Reason for Confinement

Supplementary Requirements *(please tick the requirements you have attached to this form)*

☐ Certified copy of Death Certificate ☐ Certified copy of Birth Certificate or NID Certificate ☐ Certified Medical Reports ☐ Police Report *(if required)*

SECTION E. ACCIDENTAL TOTAL AND PERMANENT DISABILITY CLAIM

For any Accidental Total and Permanent Disability Claim, your Medical Provider must complete the Medical Provider's Statement on Page 5 and post it directly to BSP Life or call BSP Life to uplift the document.

1. State the nature of the injury which caused you to cease your work/current duties.

2. When did the accident happen that caused your injury?

3. Have you previously had this injury which has been aggravated by the accident? ☐ Yes ☐ No ► *If Yes, please provide details.*

4. Do you expect to return to work or your current duties:

5. Are you entitled to any other disability benefit or compensation under the Workers' Compensation Act? ☐ Yes ☐ No ► *If Yes, please provide details below.*

Name of Insurer

Telephone **Email/Facsimile**

Postal Address

6. State names and addresses of Medical Providers attending to you who would be able to provide information regarding your condition and treatment.

Name of Medical Provider	Address	When Treated	Nature of Treatment

7. Are you required to regularly attend any surgery, hospital or clinic for treatment? ☐ Yes ☐ No ► *If Yes, please provide details below.*

Name and Address of Medical Provider	How Often	Treatment (X-Ray, injection etc.)

8. Please describe your work/current duties in detail and whether or not you use special equipment or tools: *(Please list).*

Details of Current Work/Duties	Tools/Equipment Used

9. Does your work/current duty involve any physical requirements (e.g. lifting or carrying load)? ☐ Yes ☐ No ► *If Yes, please provide details below.*

10. Have you been able to perform any of your work/current duties since your disability happened? ☐ None ☐ Part Time ☐ Full Time

SECTION F. PERSONAL ACCIDENT CLAIM

For any Personal Accident Claim, your Medical Provider must complete the Medical Provider's Statement on Page 5 and post it directly to BSP Life or call BSP Life to uplift the document.

1. State the nature of the injury caused by the accident.

2. When and how did the accident happen? *(Please attach on separate sheet if insufficient space)*

3. When did you first consult a Medical Provider? _____ ►*Please give Medical Provider's name and details below*.

Name of Medical Provider

Telephone **Email/Facsimile**

Postal Address

4. Name of Employer at the time of the accident and your weekly earnings.

Employer's Name	Your Position/Title	Weekly Earnings

5. Are you entitled to any other compensation for this accident from any other company or under the Workers' Compensation Act?

☐ Yes ☐ No ► *If Yes, please give company's name and contact details below*

Name of Company

Telephone **Email/Facsimile**

Postal Address

6. Have you had any previous accidents requiring medical attention? ☐ Yes ☐ No ► *If Yes, please give Medical Provider's name and contact details below*

Name of Medical Provider

Telephone **Email/Facsimile**

Postal Address

7. What work/current duties are you unable to perform? ► *Please give details*

1

2

3

BSP Classification: Internal Use Only

4

8. How long have you been completely incapacitated and unable to perform work/current duty due to this accident? _____ Weeks.
9. How long have you been partially disabled and unable to perform one or more work/current duties due to this accident? _____ Weeks.
10. If you are still disabled please state when you expect to return to partial or full time work/current duties? From _____.

SECTION G. CLAIM PAYMENT DETAILS

(Policy Owner to Complete)

Bank Name & Branch	Bank Account Name	Bank Account Number

SECTION H DECLARATION AND AUTHORISATION

(Benefit Payment will only be made if premium payments are in order)

I understand that Benefit payments will only be made to the Policy Owner.

I declare that the information provided in this form is true, complete and correct.

I understand that BSP Life will use the information provided in this form for the purpose of evaluating the claim.

I authorise any medical professional, hospital or other medical care institution, medical laboratory, insurance support organisation, pharmacy, government agency, insurance company, employer or benefit plan administrator, to provide to BSP Life any information concerning my/the Life Insured's employment, or insurance or any medical information to determine the benefits applicable under the Policy.
I confirm that I am duly authorised to provide this statement.

I agree that photocopy of this authority will be as valid as an original.

Claimant:

Name

Address

Signature/Thumbprint

Signed at:

Date:

Policy Owner

Authorised Person Name

Designation

Signature

Signed at:

Date:

MEDICAL PROVIDER STATEMENT

(To be completed for Accidental Total Permanent Disability and Personal Accident claim)
Please ask your Medical Provider to complete this statement. BSP Life is NOT liable for any charges levied by your Medical Provider.

PLEASE COMPLETE ALL DETAILS IN BLOCK LETTERS

1. What is your patient claiming?

   ☐ Accidental Total and Permanent Disability (TPD) ☐ Personal Accident (PA) Scale _____

2. Patients Name: _____ Date of Birth: _____

3. Diagnosis or nature of injury: *(Please indicate primary and secondary)*

4. Date of injury?

5. How long have you known the patient?

6. Date patient consulted you for this injury:
   First Consultation:
   Last Consultation:

7. List all the dates on which the patient has consulted you for this injury:

Date	Treatment Received	Date	Treatment Received

8. Are you treating the patient for this injury? ☐ Yes ☐ No

9. Was this injury an emergency? ☐ Yes ☐ No

10. Objective findings: *(Please give details of any X-Ray, ECGs or Other Tests)*

Date	Test	Results

11. Nature of treatment: *(Please include any complications)*

12. Has the patient consulted you for any other condition in the past five (5) years? ☐ Yes ☐ No ► *If Yes, please give details below.*

Reason for Consultation	Date Consulted	Treatment/Advice Received

13. Is this current injury a recurrence? ☐ Yes ☐ No

BSP Classification: Internal Use Only

14. Has the patient had a similar injury? ☐ Yes ☐ No ► *If Yes, please give details below.*

Date	Nature of Injury or Illness	Treatment Results

15. Are there any other conditions or circumstances affecting recovery from the current injury? ☐ Yes ☐ No ► *If Yes, please advise nature of condition or circumstance and how it affects recovery.*

16. Date of Total Disability:

From: To:

17. Date of Partial Disability:

From: To

18. Additional Remarks

19. Medical Provider's Name:

Telephone: Email/Facsimile:

Postal Address:

Medical Provider's Signature: Date:

Registration No.: Stamp:

INSTRUCTION TO MEDICAL PROVIDER

Please send the **Medical Provider Statement** in an envelope marked "CONFIDENTIAL" to:

The Group Policy Administrator
BSP Life PNG Limited
Waigani Banking Centre, Section 34, Allotment 6&7, Klinki Street, Waigani Drive
P O Box 78, Port Moresby, National Capital District, Papua New Guinea

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