HEALTH INSURANCE
INSURED MEMBER DEATH CLAIM FORM

This form should be used when submitting a claim under the death benefit of your health insurance policy.

THIS SECTION SHOULD BE COMPLETED BY THE EMPLOYER HUMAN RESOURCE DEPARTMENT. PLEASE PRINT IN CAPITAL LETTERS

Please provide the below information. To avoid any delays in the processing of your claim, please ensure that:

1. All claim documents submitted are clear to read.
2. All necessary claim documents are to be submitted within 30 days of the incurred date. Subject to your policy terms and conditions, claims submitted more than 90 days after the incurred date may be denied.
3. All the required information is provided (marked with *). Without all the required info we will be unable to approve your claim.

Section 1 Plan Member/Employee Information

Please print clearly

Employer Name:*			
Employee Full Name:*			
Occupation/Rank		D.O.B (dd/mm/yyyy):*	

Section 2 Beneficiary Details

Full Name:*	
D.O.B:*	

Relationship to Member:* ☐ Natural Parent ☐ Spouse (Legal) ☐ Dependent Child ☐ Other

If the relationship is "other" please specify.

Section 3 Payment Details and Authorisation

By completing this section I request that all amounts payable from this claim are paid to the account details below:

Bank:*		Account Name:*	
BSB:*		Account Number:*	

Authorization Statement
I hereby certify that all answers and all original documents submitted with the claim form are complete and true. I hereby authorize any doctor, hospital, or medical provider, any insurance company or any other company, institution or any other person who has any record or information about me and/or any of my family members to provide Parnell Assurance PNG Ltd with the complete information's, including copies of their records with reference to my sickness or accident, any treatment, examination, advice, or hospitalization. Any photocopy of this authorization shall be taken as the original copy.

Disclaimer
I verify that the documentation submitted electronically is true and unaltered and I have all the original documents that can be presented upon request of the Insurance Company. I also accept and recognize that at the sole discretion of Parnell Assurance PNG Ltd, these documents may be requested at any time during a period of one year counted from the submission of the claim, which I will provide within a period not exceeding 30 days from the request. Failing to comply could imply the claim to be declined. If the case is confirmed to be declined, I will reimburse any amount paid by Parnell Assurance PNG Ltd to me or to any party as related to this claim.

Along with this form please attach:

1. **Death Certificate, clearly outlining cause of death (must be signed and stamped by the attending doctor)**
2. **Warrant to Bury**
3. **Any other medical report or supporting documents issued by the hospital or attending doctor**

HR Officer Name : ______________________________

HR Officer's Signature:* ______________________________ **Date (dd/mm/yyyy):*** ________________

Please also add company stamp: