PT ASURANSI ALLIANZ LIFE INDONESIA

CLAIM FORM - DEATH

FILLED BY THE BENEFICIARY

Please answer the following questions completely and honestly, so we can process the claim quickly. Please do not answer with mark or symbol.

If Beneficiary is US person or US related, then it is required to fill in the 'FORM FATCA – CLAIM-INDIVIDUAL' Form.

If Beneficiary is company (institution), then it is required to fill in the 'FATCA – COMPANY(INSTITUTION)' Form.

In order to process the claims, in accordance with general provisions stated in the policy, the following documents should be submitted:

1. The original policy of ALLIANZ LIFE INDONESIA
2. Copy legalized of death certificate from Lurah
3. Copy legalized of death certificate from Catatan Sipil
4. Claims form filled completely by the Beneficiary
5. Attending Physician's Statement form filled by the doctor who stated the death or treated him / her before the death
6. Official report from police for unnatural death or death caused by accident
7. Chronology report if Insured passed away at home
8. Death certificate from Indonesian representative (embassy) if death happened abroad
9. Copy identity card of the Insured
10. Copy identity card of the Beneficiary
11. Power of Attorney to Disclose Medical Record Form
12. Other document (if needed)

Data of Policy Holder

Name	:	Policy No.	: .....
Birth Place / Birth date	:	Identity No.	: .....
Citizenship	:	Occupation	: .....
Correspondence Address	:		
	.....		
City	:	Postal Code	: .....
Province	:	Country	: .....
Telephone	:		

Data of Insured

Name	:	Citizenship	: .....
Birth Place / Birth Date	:	Identity No.	: .....
Correspondence Address	:		
	.....		
City	:	Postal Code	: .....
Province	:	Country	: .....
Telephone	:		
Place of Death	:	Date of Death	: .....
Cause of Death	:		
Job	:		

Data of Beneficiary

Name : …… Occupation : ……
Birth Place / Birth Date : …… Country of Birth : ……
Identity Type : …… Identity Number : ……
Country of Identity Issuer : …… Citizenship : ……
Country of Residence for Tax Purposes : ……
ID Address : ……
……
City : …… Postal Code : ……
Province : …… Country : ……
Telephone : ……

Do your correspondence Address is different with ID Address? ☐ Yes ☐ No
If yes, please fill Correspondence Address data
Correspondence Address : ……
……
City : …… Postal Code : ……
Province : …… Country : ……

Additional Information

Other life / health / accident insurance owned by the Insured

No.	Company's Name	Policy Number	Sum Insured	Insurance type (life/health/accident)	Commencement Date

Information about the death incident and disease / consultation history

1. Has the Insured person died suddenly (not suffering from illness) ? ☐ Yes ☐ No
   If "no", please answer questions a, b and c

   a. When did the Insured complain of or show any indication, symptom of his last illness?

   b. When did the Insured first consult to the doctor for his last illness?

   c. Name and address of all physicians who ever treated the insured

Doctor's Name	Address	Date consultation

2. Give details of any other illnesses ever suffered by the Insured

3. Give the name and address of the doctor who stated death

4. Give the name and address of the Clinic / Hospital / Doctor that ever visited by the Insured

No.	Hospital / Clinic / Doctor's Name	Address	Phone

Information about the accident (if the cause of death was due to accident)

Please give the answer that will give a clear illustration of the accident. Please enclose the newspaper article or employee report if any.

5. When and how did the accident occur ?
   (please give details and use back page for more information)

6. Place of accident (please give details)

7. During which activity or on what occasion did the accident occur ?

8. Are there any witnesses when the accident occurred? ☐ Yes ☐ No
   If "yes" please give details the names and address

9. In case of traffic accident
   a. Who was the driver at the time of accident ?

   b. Was the driver holding a valid driver's license ? ☐ Yes ☐ No

   c. Are there any other passenger at the time of accident ? ☐ Yes ☐ No
      If Yes, Who ?

10. At the time of accident, was the Insured suffering from any illness or injury ? Y / N
    If "yes" please provide details

11. How much and what kind of alcohol did the Insured drink before the accident (if any) ?

    a. Was there a blood – alcohol test ? ☐ Yes ☐ No
       If "yes" what is the result ?

    b. Was he / she under the influence of drug ? ☐ Yes ☐ No

    c. Was there an autopsy or post mortem examination ? ☐ Yes ☐ No
       If "yes" please give the result and by whom the examination conducted ?

12. Was there a police investigation ? ☐ Yes ☐ No
    If "yes" please explain when, where and by whom ?

Statement

I declare that all answers in this application form are correct and completely true. If there is any misleading or wrong information, I dispose to be remanded to the court and the insurance benefit will be returned to PT Asuransi ALLIANZ LIFE INDONESIA

Hereby I/We authorize to Allianz to disclose my personal/our/company(institution) information in serving the court summon or legal process or the request of any regulator or authority including those in any jurisdictions or to protect against fraud or other illegal activities or for risk management purposes or to allow Allianz to do any remedies available or to minimize the damage that may occur against Allianz and/or to comply with the law or legal process including but not limited to FATCA regulation ("Relevant Requirements").

I/We further undertake to provide any information or documents as requested to comply with the Relevant Requirements ("Relevant Information") and to promptly update Allianz the Company of any changes to the Relevant Information.

Place ……, date …….

Signature of beneficiary
Name : _____