



## NOTICE OF CLAIM

1. NOTIFICATION DETAILS		
<b>a. POLICY NO</b>		<b>b. CLAIM ON</b>
		Name:
		NRIC:
<b>c. NOTIFIED BY</b>		<b>d. ATTENDED BY</b>
Name:		Name:
Contact No:		Date:
Relationship with the person claimed on:		Branch/ Department:
Bank & Branch (if notified by banker):		
2. NATURE OF CLAIM		
<input type="checkbox"/> ACCIDENT INDEMNITY <input type="checkbox"/> MEDICAL CLAIM—PAY&FILE/PRE-HOSPITALISATION/POST-HOSPITALISATION/EMERGENCY OUTPATIENT <input type="checkbox"/> HOSPITALISATION & SURGICAL CLAIM <input type="checkbox"/> DEATH <input type="checkbox"/> TOTAL AND PERMANENT DISABILITY <input type="checkbox"/> CRITICAL ILLNESS <input type="checkbox"/> TRUE LADY BENEFIT – SNATCH THEFT, MARRIAGE BONUS, CHILDBIRTH BONUS ETC. <input type="checkbox"/> WAIVER OF PREMIUMS (WOP) / FAMILY INCOME BENEFIT (FIB)		
3. DETAILS OF CLAIM		
ACCIDENT CLAIM		
Date of Accident	Type of Accident	
HOSPITALISATION CLAIM		
Was Gibraltar BSN Life medical card used for the hospitalization admission?		
<input type="radio"/> Yes <input type="radio"/> No		
Date of Hospitalisation	Name of Hospital	Cause of Illness/Diagnosis
DEATH CLAIM (Please attach a copy of the death certificate)		
Date of Death	Date of Accident (if the death is due to accident)	Cause of Death
TOTAL AND PERMANENT DISABILITY CLAIM		
Date of Disability Started	Date of Accident (if the disability is due to accident)	Cause of Disability
CRITICAL ILLNESS CLAIM		
Date of Diagnosis		Type of Critical Illness
4. CLAIMS DEPARTMENT TO FOLLOW - UP		
Claim forms given?	Claim forms send to:	Address:
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> System address <input type="radio"/> Else, send to following address:(if bank, state which bank and branch)	