



MUI Continental Insurance Berhad (29123-D)

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A member of The MUI Group
In Association with CNA Insurance, USA

PERSONAL ACCIDENT DEATH CLAIM FORMS

CLAIM NO.

This form is issued without admission of liability. Any documentary proof of death and/or other reports required by the Company shall be furnished at the expense of the Claimant(s)

THE INSURED	Name: Address: Policy No. Expiry Date: Principal Sum Insured:
THE DECEASED	Name: Address: Occupation: Age: Sex: Marital Status: Date and Place of Death: Cause of Death: Give the name and address of every physician who attended the deceased during the last five years. State also the nature of illness and/or disease treated by each physician.: (1) (2) (3) Was the deceased holding any life, personal accident and/or hospitalisation policy/policies with any other Company? If yes state type of policy, amount insured, date issued and name of Company. (1) (2) (3)
THE CLAIMANT	Name: Age: Address: Telephone No: Relationship to Deceased:
THE ACCIDENT	Date and Time: Location: How exactly did the Accident occur? (Use a supplementary sheet, if necessary) Name and Address of Witnesses to the Accident: (1) (2) (3) If accident occurred at place of employment, was the Labour Department notified? Give the name of the Policy Station where the accident was reported: If deceased was admitted to a hospital prior to death, give the name and address of the hospital:

I/We hereby declare that the above answers and statements are full and true to the best of my/your knowledge and belief and that I/We have not withheld from the Company any material fact.

I/We enclose a copy of the Death Certificate of the deceased and agree to furnish of my our expense any other reports required.

Date:

Signature of Claimant