PUBLIC SERVICE NIUCARE ASSOCIATION Inc.

Policy No.	
Member No.	
File No.	
NID No.	

Level 5, Tower A, Waigani, NCD, Central Government Office (CGO) | PO Box 770, Port Moresby, National Capital District | Email: info@niucare.com.pg | Telephone: (675) 327 6381 / 327 6403

DEATH / FUNERAL CLAIM FORM (DEPENDENT)

NAME OF MEMBER:

MEMBER No: POLICY No:

ADDRESS: PHONE No:

EMAIL:

DECLARATION

ARE ANY OF THE DEATH BENEFITS CLAIMED, RESULTING OUT OF THE FOLLOWING CATEGORIES:-

* WORK RELATED WHICH ENTITLES YOU TO WORKERS COMPENSATION CLAIM? **YES** ☐ **NO** ☐

* RELATED TO MOTOR VEHICLE ACCIDENT? **YES** ☐ **NO** ☐

* DEATH IN ANY MANNER RELATED TO ENGAGEMENT IN ACTS AGAINST PUBLIC POLICY, IF YES, PLEASE ATTACH POLICY REPORT? **YES** ☐ **NO** ☐

If the response is **YES** to any of the above, please give details

PAYMENT DETAILS

Claim payment options to be made to the nominated banks accounts only. For corporate members HR Departments payment instructions if any, take precedence. Please provide the following information below:

ACCOUNT HOLDER NAME:	
BANK NAME:	
BRANCH BSB No:	
ACCOUNT NUMBER:	

NOTE

TURN OVERLEAF TO PROVIDE PROFESSIONAL MEDICAL TREATMENT AND SERVICE DETAILS

IMPORTANT NOTICE

1. ORIGINAL RECEIPTS WITH VALID STAMP MUST BE ATTACHED.

2. PERSONS DECLARED IN ORIGINAL PROPOSAL/APPLICATION FORM CAN BE ELIGIBLE FOR A CLAIM.

3. ENSURE THAT ALL COLUMNS OF CLAIM FORM ARE FILLED INCLUDING THE DECLARATION SECTION.

DEATH DETAILS

Assured Person Name	Relation to Member	Date of Birth	Date of Death	Place of Death (Please attach Original Death Certificate)	Cause of Death

SUM ASSURED*

BENEFIT	SUM ASSURRED
FUNERAL	**PGK**
DEATH	**PGK**

DECLARATION

I/We do solemnly and sincerely declare that answers in the declaration section are full and true and that I have not withheld any relevant information. Further I accept the responsibility that if any information is false, the company reserves the right to repudiate the claim.

I/We hereby authorise any physician or any organization that has any records of my health to furnish to **Public Service Niucare Association Inc. (PSNA)** with information concerning my medical history and physical condition.

MEMBER SIGNATURE: _____ **DATE:** _____

OFFICE USE: **ORIGINAL DOCUMENTS MUST BE ENCLOSED**

Death Certificate Checked ☐ Plan Commencement Date ___/___/___ Date of 1st Contribution ___/___/___

Application for Membership Checked ☐ Checked by: _____ **CLAIM No.** _____ **BATCH No.** _____