



PUBLIC SERVICE NIUCARE ASSOCIATION Inc.

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

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DEATH / FUNERAL CLAIM FORM (MEMBER)

NAME OF MEMBER: _____

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

*IN THE EVENT OF DEATH OF MEMBER BENEFITS WILL BE PAYABLE TO THE DECLARED BENEFICIARIES AS PER WILL KIT

NOTE

TURN OVERLEAF TO PROVIDE DETAILS OF CLAIM

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

Member Name	Date of Birth	Date of Death	Place of Death (Please attach Original Death Certificate)	Cause of Death

SUM ASSURED*

BENEFIT	SUM ASSURED
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.

NEXT OF KIN SIGNATURE: _____ **DATE:** _____

NEXT OF KIN NAME: _____

EMPLOYER REPRESENTATIVE SIGNATURE: _____ **DATE:** _____

EMPLOYER REPRESENTATIVE NAME: _____

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.** _____