ElderShield **CLAIM FORM**

Dear Policyholder,

We are sorry to learn of your disability.

In order for us to process your claim, please:

1. Complete the attached Claim Form as best as you can. If you are unable to do so, please have it completed by your immediate family member or caregiver.

2. Call the clinic to make an appointment for the severe disability assessment. Please refer to the list of appointed assessors at http://www.aviva.com.sg/pdf/appointed_assessors.pdf. The fee for the assessment is to be paid by you.

3. Bring along the following for the appointment:
   - Completed Claim Form
   - Completed Letter of Undertaking and Indemnity (if payee is other than the Policyholder)
   - Hospital medical records and discharge summary that you may have
   - Medicine (if any)

Once we have received all the required documents/information, we will process your claim and inform you of the outcome as soon as possible.

If you need help, please contact our staff at **6827 7788** or email us at **cs_life@aviva-asia.com.**

乐龄健保 索赔表格

敬爱的保单用户，
我们十分同情您的处境，也希望尽快地给予保单赔偿。

为了尽快地处理您的索赔申请，请您：

1. 填妥后面附的索赔表格。如果自己无法填写，可请亲属或看护人代为填写。
2. 登录我们的网站http://www.aviva.com.sg/pdf/appointed_assessors.pdf。从我们所指定的评估医生名单中选出一名评估员，并预约评估时间，请他评估您的残疾情况。不过，评估费自理。
3. 在评估当日携带下列文件赴约:
   - 填妥的索赔表格
   - 填妥的担保书 (如果收款人并非保户)
   - 完整的病历和出院单 (如有)
   - 正在服用的药物 (如有)

一旦收到全部所需资料，我们会尽快处理您的索赔，并及时通知您索赔的结果。

若您需要协助，请联络 **Aviva 6827 7788** 或电邮于 cs_life@aviva-asia.com.

Aviva Ltd 4 Shenton Way #01-01 SGX Centre 2 Singapore 068807 Tel: (65) 6827 7988 Fax: (65) 6827 7900 Website: www.aviva.com.sg
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ElderShield **BORANG TUNTUTAN**

Pemegang Polisi,

Kami bersimpati di atas keadaan kesihatan anda.

Untuk memproses tuntutan anda itu, sila:

1. Isikan borang tuntutan anda. Jika anda tidak berupaya mengisi borang tersebut, keluarga anda boleh membantu mengisikan borang itu.

2. Hubungi klinik untuk membuat temujanji bagi penilaian ketidakupayaan. Anda boleh rujuk kepada senarai penilai yang dilantik daripada lelaman kami (http://www.aviva.com.sg/pdf/appointed_assessors.pdf). Anda juga dikehendaki membayar yuran penilaian dendiri.

3. Bawa bersama dokumen-dokumen berikut sewaktu penilaian itu:
   - Borang Tuntutan anda yang telah dilengkapi
   - Surat Akujanji dan Tanggung Rugi yang telah dilengkapi (jika penerima tuntutan lain daripada pemegang polisi)
   - Rekod kesihatan anda dari hospital dan juga surat pengesahan pesakit (Inpatient discharge summary)
   - Ubat-ubat anda (jika ada)

Kami akan memproses tuntutan anda setelah menerima segala dokumen yang diperlukan dan akan menghubungi anda secepat mengkin.

Jika anda memerlukan bantuan, sila hubungi kami di **6827 7788** atau emel kami di **cs_life@aviva-asia.com.**

எல்டர்ஷூல்டு கோரிக்கை படிவம்

அன்புடையீர்

தங்களுக்கு ஏற்பட்டுள்ள இயலாமை நிலை அறிந்து வருந்துகிறோம்.

மேற்கொண்டு நாங்கள் செயலாற்ற பின் வருவனவற்றை செய்யுங்கள்.

1. இனணக்கப்பட்டுள்ள கோரிக்கை படிவத்னத தங்களால் இயன்ற வரை பூர்த்தி செய்யுங்கள். தங்களால் இயலவில்லை என்றால் நெருங்கிய குடும்ப உறுப்பினரோ அல்லது தங்களைத் தற்போது கவனித்துக்கொள்பவரோ பூர்த்தி செய்யலாம்.
2. மருத்துவ பரிசோதனை செய்துகொள்ள நாள் குறிக்க மருந்தகத்தை அழையுங்கள். இனணக்கப்பட்டுள்ள நியமன ஆய்வாளர் படடியலைக் காண்க (http://www.aviva.com.sg/pdf/appointed_assessors.pdf).மருத்துவ பரிசோதனை கட்டணத்தை நீங்கள் கொடுக்க வேண்டும் என்பதை தெரிவித்துக்கொள்கிறோம்.
3. பரிசோதனனக்கு செல்லும் போது பின் வருவனவற்றை எடுத்துச் செல்லுங் கள் :
   - பூர்த்தி செய்த கோரிக்கை படிவம்
   - பூர்த்தி செய்யப்பட்ட பொறுப்பேற்பு மற்றும் சட்ட விலக்குரிமைக் கடிதம் (பணம் பெறுபவர் பாலிசிதாரர் / விண்ணப்பதாரராக இல்லாமல் வேறொருவராக இருந்தால்)
   - உங்களிடம் இருக்கிற நோய் தொடர்பான தகவல்கள் (Medical Reports)
   - உட்கொள்ளும் மருந்துகள் (முடிந்தால்)

அனைத்து தகவல்களும் சான்றிதழ்களும் எங்களுக்கு கிடைத்தவுடன் உங்கள் கோரிக்கையை பரிசீலனை செய்து முடிவை உங்களுக்கு தெரியப்படுத்துவோம்.

உங்களுக்கு உதவி தேவைப்பட்டால் தயவு செய்து **6827 7788** எண்ணுக்கு அழைக்கவும் அல்லது cs_life@aviva-asia.com. என்று மின்னஞ்சல் செய்யவும்.

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* C L A I M F *

ELDERSHIELD CLAIM FORM

To be completed by the Policyholder or if he/she is unable to do so, by an immediate family member/caregiver.

BASIC ELDERSHIELD Policy No.:_____ Insurer: Aviva Ltd / Great Eastern / NTUC Income*

ELDERSHIELD SUPPLEMENT Policy No.:_____ Insurer: Aviva Ltd / Great Eastern / NTUC Income*

1: PERSONAL PARTICULARS

POLICYHOLDER

Name of Policyholder (as shown in NRIC)

NRIC No.	Nationality	Date of Birth (dd/mm/yyyy)	Ethnic Group ❒ Chinese ❒ Indian ❒ Malay ❒ Others	Gender ❒ Male ❒ Female

Address

Contact Number (Home) (Handphone)	Email

CAREGIVER

Name of Caregiver (full-time or part-time) *

Address of Caregiver

Relationship to Policyholder	NRIC No.
Contact Number (Home) (Handphone)	Email

BANK ACCOUNT DETAILS (IMPORTANT – Please do not leave blank)

For benefits payment to the following account of the Policyholder once claim is admitted.

Note: For payment to family member or caregiver, please complete the attached Letter of Undertaking & Indemnity.

Name of Bank Account Holder	Bank Account Number
Name of Bank	Name of Branch

Details of child below age 21 (Applicable to MyCare/MyCare Plus only)

Name of Youngest Child	Date of Birth (dd/mm/yyyy)	Place of Birth	Gender ❒ Male ❒ Female
Birth Certificate Number *(please provide copy of birth certificate of child)*	If the child is legally adopted, please state Date of Adoption (dd/mm/yyyy) *(Please provide copy of legal adoption papers)*		

2: MEDICAL HISTORY

Q1 Have you ever been admitted to hospital in the last 5 years? ❒ Yes ❒ No

If "Yes", please give details of the medical conditions and when it started.

Condition	Date Started (dd/mm/yyyy)

** Please delete accordingly*

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2: MEDICAL HISTORY (continued)

Q2	Please state other medical conditions, if any (e.g. stroke, hypertension, heart disease, diabetes mellitus, etc), that you are suffering from.
Q3	Name and address of your regular doctor.
Q4	If disability is due to accident, please provide date of accident: _____ / _____ / _____ (dd/mm/yyyy), and attach a copy of accident report. If no report is available, please describe: (a) nature of the accident and (b) extent of injuries sustained.

3: ACTIVITIES OF DAILY LIVING

Please tick against the box that most accurately describes the policyholder's ability		Date disability started (dd/mm/yyyy)
Q1	**WASHING OR BATHING -** Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means. ☐ No help is needed. ☐ Some help/supervision is needed (e.g., to wash the back, to wash hair). ☐ Needs someone to help most of the time. ☐ Not able to do at all (needs to be washed or bathed entirely by caregiver).	
Q2	**DRESSING -** Ability to put on, take off, secure and unfasten all garments (upper and lower) and, as appropriate, any braces, artificial limbs or other surgical or medical appliances. ☐ No help is needed. ☐ Some help/supervision is needed (e.g., to button clothes, to put on trousers). ☐ Needs someone to help most of the time. ☐ Not able to do at all (needs to be dressed entirely by caregiver).	
Q3	**FEEDING -** Ability to feed oneself food after it has been prepared and made available. ☐ No help is needed. ☐ Some help/supervision is needed (e.g., to scoop food, to put food in mouth). ☐ Needs someone to help most of the time. ☐ Not able to do at all (needs caregiver to feed entirely or is tube-fed).	
Q4	**TOILETING -** Ability to use the lavatory or manager bowel and bladder function through the use of protective undergarments or surgical appliances if appropriate. ☐ No help is needed. ☐ Some help/supervision is needed (e.g., to get on or off the toilet). ☐ Needs someone to help most of the time. ☐ Not able to do at all (needs to be placed on the toilet and cleaned by caregiver). ☐ Not able to do at all (needs caregiver to manage diapers and/or catheter).	
Q5	**TRANSFERRING -** Ability to move from a bed to an upright chair or wheel chair, and vice versa. ☐ No help is needed. ☐ Some help/supervision is needed (e.g., to be lifted up from lying position to sitting position from bed). ☐ Needs someone to help most of the time. ☐ Not able to do at all (needs to be carried).	
Q6	**MOBILITY -** Ability to move indoors from room to room on level surfaces. ☐ No help is needed. ☐ Some help/supervision is needed (e.g., to be supervised by someone closely in case of fall). ☐ Needs someone to help most of the time. ☐ Not able to do at all (needs to be carried).	

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4: DECLARATION AND AUTHORISATION

Note: If the policyholder has previously been assessed by a doctor to lack mental capacity*, the policyholder's appointed donee(s)/deputy(s), or caregiver if a donee(s)/deputy(s) has not been appointed, is to complete this section and sign/affix thumbprint. The mentally incapacitated policyholder need not sign off/affix thumbprint.

*A separate doctor's memo should be submitted to indicate that the policyholder lacks mental capacity, including the relevant medical reason(s).

1. I/We hereby declare that the above statements are true and complete and I/We have not withheld any material fact from Aviva Ltd.
2. I/We declare that I/We am/are not an undischarged bankrupt or insolvent or has/have executed any deed or transfer for the benefit of creditors within the last twelve (12) months.
3. I/We agree that:
   a. this declaration shall form part of my/our application for ElderShield benefits.
   b. this claim signifies my/our consent to the Insurer to obtain medical information from any doctor whom I/We have consulted and I/We authorise the doctor to release such information to the Insurer.
   c. the Insurer may release any relevant information concerning me/us (including my/our medical information) to any third party, which the Insurer deems necessary.
   d. any third party has received any information concerning me/us may also obtain medical information from any doctor whom I/We have consulted, and I/We authorise the doctor to release such information to the third party. The third party may also release relevant information concerning me/us (including my medical information) to any other party for any purposes related to my/our application or claim for ElderShield benefits.
   e. a photocopied copy of this form shall be treated as valid and binding as if it were the original.
4. I/We also consent to Aviva (and Aviva related group of companies):
   a. collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s) and/or managing my/our relationship with Aviva.
   b. disclosing my/our personal data to the Government and participating statutory boards and organisations approved by the Government to determine your and your insured person's suitability and eligibility for social and public assistance schemes.
   c. transferring my/our personal data to Aviva related group of companies and/or third party service providers, reinsurers, suppliers or intermediaries whether located in Singapore or elsewhere, for the above purposes.

For full details of the purposes of collection, use and disclosure of your personal data, please visit http://www.aviva.com.sg/pdpa.

Note: If you are filling up this form on behalf of another person or whereby you are disclosing personal data to us other than yours, you are required to inform such person(s) of the purpose and obtain his/her consent before submitting this form to us. Once you have submitted, you will be deemed to have obtained the necessary consent for us.

Name of Policyholder	NRIC/Passport No.	Signature/Thumb Print of Policyholder	Date

To be completed if form is filled up by family members / caregiver	
Name family member / caregiver*	Signature of family member / caregiver*
Relationship to Policyholder	Date

** Please delete accordingly*

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Important Note:

1. This Letter of Undertaking and Indemnity is a legal document. Please seek legal advice if you have any enquiries. Your completion of this Form will facilitate the prompt processing of your claim.
2. Please complete this Form if payment is to be made to a Third Party and to be completed by payee.

TO: AVIVA LIMITED - Individual Life Claims Department

PART I: LETTER OF UNDERTAKING & INDEMNITY

I / We declare that I am / we are the main caregiver of the Policyholder, _____

_____ (Name of Policyholder) of NRIC No._____

Policy Number _____.

In consideration of Aviva Ltd ("the Company") agreeing or having agreed, at the Policyholder's/ my / our request to pay the benefits, which the Policyholder is entitled to under the ElderShield / MyCare / MyCare Plus Policy, to me / us, I / we agree and undertake as follows:

1. That I / we will use and apply the ElderShield / MyCare / MyCare Plus benefits paid by the Company only for the care and benefit of the Policyholder.
2. That I / we will inform the Company immediately upon becoming aware that the Policyholder recovers from the disability, which refers to the inability to perform at least 3 Activities of Daily Living, or passes away.
3. That I / we will repay and Eldershield / MyCare / MyCare Plus benefits, which the Policyholder is not entitled or ceases to be entitled to, upon written demand by the Company. I / We agree and undertake that if I / we fail to make such repayment, I / we will fully indemnify the Company against any loss, damage, cost and expenses whatsoever, including any legal cost, which may be incurred by the Company as a result of my/our failing to fully repay the Eldershield / MyCare / MyCare Plus benefits or of the Company's need to enforce its rights under the Undertaking or Indemnity.
4. I/We consent to Aviva (and Aviva related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s) and/or managing my/our relationship with Aviva.
5. I/We also consent to Aviva (and Aviva related group of companies) transferring my/our personal data to Aviva related group of companies and/or third party service providers, reinsurers, suppliers or intermediaries whether located in Singapore or elsewhere, for the above purposes.

For full details of the purposes of collection, use and disclosure of your personal data, please visit http://www.aviva.com.sg/pdpa.html.

Note: If you are filling up this form on behalf of another person or whereby you are disclosing personal data to us other than yours, you are required to inform such person(s) of the purpose and obtain his/her consent before submitting this form to us. Once you have submitted, you will be deemed to have obtained the necessary consent for us.

PART II: Letter of Undertaking & Indemnity to the Government of the Republic of Singapore For Pioneer Generation Disability Assistance Scheme (PioneerDAS)

This Part applies where the Policyholder named in Part I ("Pioneer") is determined to be eligible for and is accepted into the Pioneer Generation Disability Assistance Scheme (PioneerDAS)*, a Government scheme administered by the Agency for Integrated Care (AIC).

To: the Government of the Republic of Singapore

- I/We declare that I am/we are the main caregiver(s) of the Pioneer.
- I/We agree and undertake as follows:
- I/We will use the PioneerDAS payments only for the care and benefit of the Pioneer.
- I/We will inform AIC immediately in writing if the Pioneer has passed on or ceases to satisfy the PioneerDAS Eligibility Criteria*
- Upon written demand by AIC, I/ we will refund to AIC any PioneerDAS payments paid after the Pioneer ceases to be eligible for such payments.
- I/We will fully indemnify AIC and the Government of the Republic of Singapore against any loss, damage, cost and expense whatsoever, including any legal cost on a full indemnity basis, which may be incurred as a result of my failing to abide by the terms of this Undertaking and Indemnity.

* Eligibility Criteria for PioneerDAS is as follows:
- The Pioneer is born on or before 31 December 1949;
- The Pioneer is a citizen of Singapore on or before 31 December 1986, and remains a Singapore citizen;
- The Pioneer continues to stay in Singapore; and
- The Pioneer continues to require assistance with at least 3 out of 6 Activities of Daily Living (ADLs): (i) showering/bathing; (ii) dressing; (iii) eating; (iv) toileting; (v) transferring from chair to bed or vice versa; and (vi) walking or moving on level surfaces.

For more information on PioneerDAS, please refer to AIC at 1800-650-6060 (Mon to Fri 8.30am – 6pm, Sat 8.30am – 12.30pm) or pioneerDAS@aic.sg

** Singaporeans who are members of the Pioneer Generation and who meet the criteria to qualify for basic ElderShield/ IDAPE payouts will automatically be included in PioneerDAS.*

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PART III: DIRECT CREDIT AUTHORISATION

Please attach a copy of the Bank Book or Statement showing the bank's name, branch and account number for our action.

I / We hereby authorise the Company to credit the Eldershield / MyCare / MyCare Plus benefits that are payable to the Policyholder under the Eldershield / MyCare / MyCare Plus Policy into this account and verify my / our account with the bank.

Name of Bank Account Holder(s)	
Name of Bank	Name of Branch
Bank Account Number	NRIC No.

Details of payee (age above 21 years old)

Full Name (Payee)	NRIC No.	Contact No.
Address		
Signature of Payee	Relationship to Policyholder	Date (dd/mm/yyyy)

For homes or Institutions only (if benefits are to be made to the home or Institution)

Name of home or institution		Address of home or Institution
Name of authorised officer	Contact No. of authorized officer	Home/Institution official stamp
Signature of authorized officer	Date (dd/mm/yyyy)	

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