GROUP LIFE & HEALTH CLAIMS
TOTAL AND PERMANENT DISABILITY CLAIM FORM
CLAIMANT'S STATEMENT

AVIVA LTD
Group Life & Health Claims
4 Shenton Way, #01-01 SGX Centre 2
Singapore 068807
Tel: 6827 8030 Fax: (65) 6827 7705
Company Registration No.196900499K

The insurer does not admit liability by the mere issue of this form.

Name of Company: _____ Policy No: _____

SECTION I (TO BE COMPLETED BY CLAIMANT)

1. PERSONAL PARTICULARS			
Name of Claimant	NRIC/Passport	Date of Birth (DD/MM/YY)	Gender ☐ F ☐ M
Email Address	Mobile No	Marital Status	
Present Address:			
Date of Employment (DD/MM/YY):	Commencement Date of Insurance (DD/MM/YY):		

2. DETAILS OF OCCUPATION		
Occupation	Before Disability	After Disability
Average Monthly Income (Please furnish a copy of last payroll)		
List exact duties performed at work *		

* If you are not working, please provide a list of daily activities before and after the disability. Aviva reserves the right to request for documentary evidence.

3. DETAILS OF DISABILITY		
a) Is this disability suffered due to:	☐ Illness (Date of Symptoms Started)	☐ Accident (Date / Time of Accident)
b) Describe in details all symptoms and/or nature of injuries / disability suffered		
c) Date of last work:	d) Are you currently confined to: ☐ Bed ☐ Home ☐ Neither	
e) Date you return to work _____ OR date you expected to return to work _____		

4. DETAILS OF PHYSICIAN(S) CONSULTED OR HOSPITAL(S) ADMITTED FOR THIS DISABILITY		
Name (s)	Address (es)	Admission Date (s)

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5. DETAILS OF YOUR REGULAR PHYSICIAN OR ANY OTHER PHYSICIAN(S) CONSULTED FOR ANY OTHER DISORDERS IN THE PAST THREE YEARS		
Names(s)	Address(es)	Admission Date(s)

6. OTHER CLAIMS		
Are you claiming from any other insurance company or other sources in respect of this disability? If Yes, please provide the following information:		
Name of Company	Amount Claimed	Policy No (if applicable)

AUTHORISATION & CONSENT

This part must be signed by the patient's parent / legal guardian if the patient is below 21 years old.

I/We hereby authorise any hospital, physician, person or organization to disclose when requested to do so by Aviva Ltd, any and all information with respect to any illness, or injury, medical history, consultations, prescriptions or treatment and copies of all hospital or medical records. A photostat copy of this authorisation shall be considered as effective and valid as the original.

I/We declared that the above statements and answers are true and complete to the best of my/our knowledge and belief.

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), my/our insurance coverage and/or managing my/our relationship with Aviva.

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.

Signature of Claimant:_____ Date:_____

(TO BE COMPLETED BY ASSURED COMPANY)

2) If Sum Assured is Based on Salary, please furnish a Certified True Copy (by employer) of the Insured Member's last pay slip (for a full month)	
a) Last Drawn Salary:	b) Date of Last Drawn Salary:

Signature of Employer	Company's Name / Stamp	Date

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SECTION II (TO BE COMPLETED BY ATTENDING PHYSICIAN AT INSURED'S EXPENSE)

Name of Patient:	NRIC/Passport No:

PART A – PATIENT'S CONDITION

1. CONSULTATION FOR PRESENT ILLNESS / INJUR(IES)

a) Are you the patient's usual physician? ☐ Yes ☐ No If Yes, since what date?

_____

b) When did the patient first consult you for this illness or injur(ies)?

_____

c) Please provide details on:

i) Symptoms presented _____

ii) Duration of these symptoms _____

iii) Diagnosis _____

iv) Date of Diagnosis _____

v) Was the diagnosis made known to the patient? ☐ Yes ☐ No If Yes, when? If No, why?

_____

d) If consultation was for injur(ies), please describe injuries:

_____

2. Please describe treatment, including any operations performed.

_____

_____

_____

_____

3. If the patient was referred from a clinic or hospital, please state:

a) Name of Physician: _____

b) Name of Clinic/Hospital: _____

c) Date Referred: _____

4. Has patient been admitted to hospital before for the same illness/injur(ies)? ☐ Yes ☐ No If Yes, please state

a) Date admitted _____ b) Date discharged _____

c) Name of hospital _____ d) Admission No _____

5. Has the patient suffered or is suffering from any other disease or ailment? If so, please give details

_____

_____

_____

a) Date patient first suffered from the disease or ailment _____

b) Name and address of Physician consulted _____

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6. Based on your assessment on the patient, please indicate below what best to describe the patient's disability status:

☐ Good recovery – can lead a full and independent life with or without minimal neurological deficit.

☐ Moderately disabled – has neurological or intellectual impairment but independent.

☐ Severely disabled – conscious but totally dependent on others to get through daily activities.

☐ Vegetative survival.

7. Is the patient able to return to his/her usual occupation?

☐ If Yes, please elaborate when can he/she return to work and what is the limitation?

_____

☐ If No, please elaborate to what extend does his/her disability prevent him/her from performing all the normal duties of his/her usual occupation? When can he/she return to work, what is his/her limitation?

_____

☐ What other type of occupation can the patient perform?

_____

8. In your opinion, would the patient's condition lead to death within the next 12 months from the date of diagnosis?

_____

9. Please provide us with any other additional information that will enable the company to assess this claim.

_____

_____
Signature of Physician / Surgeon

_____
Date

_____
Name / Designation

_____
Name and Address of Clinic / Hospital & Stamp

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PART B – ACTIVITIES OF DAILY LIVING

Please comment on whether the patient is able to perform the following activities of daily living:

Activity	Score
Feeding 0 = unable 5 = need help cutting, spreading butter, ect., or require soft diet 10 = independent	☐ 0 ☐ 5 ☐ 10
Bathing 0 = dependent 5 = independent (or in shower)	☐ 0 ☐ 5
Grooming 0 = needs to help with personal care 5 = independent [(face / hair / teeth / shaving (implements provided)]	☐ 0 ☐ 5
Dressing 0 = dependent 5 = need help but can do about half unaided 10 = independent (including buttons, zip, laces, ect)	☐ 0 ☐ 5 ☐ 10
Bowels 0 = incontinent (or needs to be given enemas) 5 = occasional accident 10 = continent	☐ 0 ☐ 5 ☐ 10
Bladder 0 = incontinent or catheterised and unable to manage alone 5 = occasional accident 10 = continent	☐ 0 ☐ 5 ☐ 10
Toilet Use 0 = dependent 5 = needs some help, but can do something alone 10 = independent (on and off, dressing, wiping)	☐ 0 ☐ 5 ☐ 10
Transfer (bed to chair and back) 0 = unable, no sitting balance 5 = major help (one or two people, physical), can sit 10 = minor help (verbal or physical) 15 = independent	☐ 0 ☐ 5 ☐ 10 ☐ 15
Mobility (on level surfaces) 0 = immobile or < 50 yards 5 = wheelchair independent, including corners > 50 yards 10 = walks with help of one person (verbal or physical) > 50 yards 15 = independent (but may use any aid; for example, stick) > 50 yards	☐ 0 ☐ 5 ☐ 10 ☐ 15
Stairs 0 = unable 5 = needs help (verbal, physical, carrying aid) 10 = independent	☐ 0 ☐ 5 ☐ 10

Signature of Physician / Surgeon

Date

Name / Designation

Name and Address of Clinic / Hospital & Stamp