DISABILITY &/OR TERMINAL ILLNESS CLAIM - CLAIMANT'S STATEMENT

Dear Claimant
We're sorry to receive notice of the Life Assured's condition. To enable us to process your claim, please follow the instructions below:

HOW TO FILE A DISABILITY and/or TERMINAL ILLNESS CLAIM

Documents Required:

1. Disability &/or TI Claim Form: Section 1 – Claimant's Statement
2. Disability &/or TI Claim Form: Section 2 – Doctor's Statement (to be completed by the attending doctor)
3. Clinical Abstract Application Form
4. Copies of all diagnostic reports, including laboratory tests results, biopsy and/or histopathology report, ultrasound report, coronary angiography, isotope studies imaging, CT scans, and any relevant hospital reports that are available.
5. Newspaper Clipping (if any)
6. Police Investigation Report (if any)
7. Copy of the NRIC/FIN or Passport of the Life Assured
8. Copy of the NRIC/FIN or Passport of the Policy Owner, if different from Life Assured
9. Any other documents that support the claim (e.g. official certificate of appointment of the legal guardian of Life Assured who is a minor)
10. Proof of Policy Owner's relationship with Life Assured as follows (where applicable):

Policy Owner	Documents required
Spouse	Marriage Certificate of Policy Owner
Children	Birth Certificate of Life Assured
Parent	Birth Certificate of Life Assured
Sibling	Birth Certificate of Life Assured and Policy Owner

Additional documents required for Disability Income Benefit Claim:

11. Employment and/or Income documents, e.g. confirmation from employer on absence from work, termination letter, pay slips, IR8A Form, CPF Statements, Commission Statement, etc.
12. Copies of all medical leave certificates

IMPORTANT NOTES:

1. All questions in the Claimant's Statement must be fully and truthfully answered. We reserve the right to pursue for any documents that are not mentioned above if they are deemed necessary.
2. These said documents shall be in the forms as prescribed by Aviva Ltd and shall be furnished at the expense of the Claimant(s).
3. The cost of the Doctor's Statement and/or medical evidence shall be borne by the Claimant(s).
4. For Doctor's Statement or reports to be obtained from hospitals, specific Clinical Abstract Forms may be used. Please refer to the respective hospital's website for details. For clinics, please use Aviva's Clinical Abstract Application Form.
5. Copies of the supporting document(s) may be certified to be true copies by our Customer Service Executives at Aviva's Customer Service Centre or a Solicitor. Please note that the original documents have to be produced for certification.
6. For treatment and surgical procedure which occurred overseas, original documents and supporting documents can only be certified by the Notary Public of the Country where Life Assured seek treatment and undergone the surgical procedure.
7. All documents submitted must be in English. Any documents which are in foreign languages must be officially translated to English by a certified translator/interpreter.
8. If the Policy has been assigned, original Assignment Deed is required.
9. All claims required documents can be submitted to Aviva Ltd through the Aviva's distributors. Alternatively, you may submit the claim personally to our Customer Service Centre.
10. Aviva Ltd is required to collect certain information about each person's tax residency and tax classifications under applicable tax regulations, including the Singapore Income Tax Act (Chapter 134), the Foreign Account Tax Compliance Act (FATCA) and the OECD Common Reporting Standard for Common Exchange of Financial Account Information (CRS). We may be legally obliged to give the Internal Revenue Authority of Singapore (IRAS) this information, along with information relating to your policies of which you are an Account Holder, which may be shared between different countries' tax authorities. If you have any questions on how to determine your tax residency status, please contact a professional tax adviser as we are not allowed to give tax advice.
11. For the purpose of Foreign Account Tax Compliance Act (FATCA), a US Person means:
    (a) a US citizen or resident individual,
    (b) a partnership or corporation organised in the US or under the laws of the US or any State thereof, a trust if:
        (i) a court within the US would have authority under the applicable law to render orders or judgments concerning substantially all issues regarding the administration of the trust; and
        (ii) one or more US persons have the authority to control all substantial decisions of the trust, or an estate of a decedent that is a citizen or resident of the US.

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CLINICAL ABSTRACT APPLICATION

To whom it may concern:

_____
_____
_____
_____

Dear Sir/Madam

Please furnish **AVIVA LTD** with a detailed medical report on:

_____ NRIC / BC _____
(Name of Patient)

This report is required for insurance purposes. Upon receipt of this application from **AVIVA LTD**, you may furnish a detailed medical report (together with histology report, laboratory results, etc.) whether for use in connection with litigation or for other legitimate purposes.

I agree that a copy of this authorisation form shall be considered as effective and valid as the original.

_____
Signature of Patient
(if Patient is above 21)

Name : _____

Address : _____

_____

_____

NRIC No : _____

Date : _____

_____
Signature of Next-Of–Kin
(if Patient is below 21)

Name : _____

Address : _____

_____

_____

NRIC No : _____

Date : _____

Relationship to Patient : _____

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* C L A I M F *

AVIVA

DISABILITY &/OR TERMINAL ILLNESS CLAIM - CLAIMANT'S STATEMENT

IMPORTANT:

1. Please read page 1 "**How to File a Disability and/or Terminal Illness Claim**" before you complete this Form.
2. The Life Assured/Assured will be responsible for the accuracy and integrity of the information provided. Failure to provide details or disclose all relevant information may delay the claim assessment.
3. The Assured shall bear the cost of medical reports (if any).
4. Please continue to pay the premiums until we have informed you on the outcome of the claim.
5. Aviva Ltd does not admit liability by the mere issue of this or any other form.

SECTION 1 – To be completed by the Claimant

POLICY NUMBER(S):			
Type of Claim (please √ box) ❒ Total & Permanent Disability ❒ Disability Income ❒ Terminal Illness			
A. Details of Life Assured			
Name of Life Assured			
NRIC/FIN/Passport/BC No.	Gender	Date of Birth(dd/mm/yyyy)	Marital Status
B. Details of Assured (if different from Life Assured)			
Name of Assured			
NRIC/FIN/Passport No.	Gender	Date of Birth (dd/mm/yyyy)	
C. Details of Disability/Illness			
1) Date the Life Assured FIRST consulted doctor for the condition (dd/mm/yyyy)			
2) Name of Doctor and address of Hospital/Clinic			
3) Describe Symptoms presented			
4) Date symptoms FIRST started (dd/mm/yyyy)			
5) Exact diagnosis		6) Date of FIRST diagnosis (dd/mm/yyyy)	
7) Has the Life Assured previously suffered from or received treatment for a similar or related Disability/Illness? If "Yes", please provide full details.			❒ Yes ❒ No

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C. Details of Disability/Illness (continue)

8) Is the Disability/Illness a result of an Accident? ❒ Yes ❒ No

If "No", please proceed to Question 9. If "Yes", please provide details as follows:

a) Date of Accident (dd/mm/yyyy) b) Time of Accident

c) Place of Accident

d) Describe in detail how the accident happened.

e) Describe the nature and extent of injuries/disability sustained, including exact site(s) of the body.

f) Was the accident reported to the Police? ❒ Yes ❒ No

If "Yes", please provide a copy of the police investigation report.

9) Is the Life Assured currently confined to (please √ where is applicable)

❒ Bed ❒ House ❒ Hospital ❒ Others (please specify):_____

Date confinement started: (dd/mm/yyyy)

10) Date the Life Assured Returned to work: (dd/mm/yyyy)

11) If the Life Assured has not returned to work, date he/she is expected to return to work. (dd/mm/yyyy)

12) Details of doctor(s) consultation and/or hospital(s) admission for **THIS** Disability/Illness

Name of Doctor & Address of Hospital/Clinic	Date of First Consultation (dd/mm/yyyy)	Date of Last Consultation (dd/mm/yyyy)	Treatment Provided

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C. Details of Disability/Illness (continue)

13) Has the Life Assured been hospitalised for condition(s) **RELATED** to **THIS** Disability / Illness? ❒ Yes ❒ No

If "Yes", please state:

Name of Doctor & Address of Hospital	Date of Admission (dd/mm/yyyy)	Date of Discharge (dd/mm/yyyy)	Reasons for Hospitalisation	Treatment Provided

14) Details of Life Assured's doctor(s) consultation for any **OTHER** disorders / conditions

Name of Doctor & Address of Hospital/Clinic	Date of First Consultation (dd/mm/yyyy)	Date of Last Consultation (dd/mm/yyyy)	Reasons for Consultation	Treatment Provided

15) Is the Life Assured claiming from any other Insurer(s) or other sources in respect of **THIS** Disability / Illness? If "Yes", please provide the details. ❒ Yes ❒ No

Name of Insurer	Type of Plan	Sum Assured	Claim Notified

D. Daily Activities Before and After Disability/Illness

1) List the daily activities the Life Assured engaged **Before** this Disability/Illness.

2) List the daily activities the Life Assured engages **After** this Disability/Illness.

3) Please elaborate what is preventing the Life Assured from doing the daily activities he/she used to engage before this Disability/Illness.

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E. Details of Life Assured's Occupation (just before the Disability/Illness)			
1) Occupation (Title and Job Duties)			
2) Name & Address of Employer			
3) Employment Status (please √ box)	❒ Full-Time ❒ Part-Time ❒ Contract ❒ Temporary ❒ Unemployed		
4) Date of Employment (dd/mm/yyyy)		5) Date Last Worked (dd/mm/yyyy)	
6) Date this Disability has totally and permanently prevented the Life Assured from performing the material duties of his/her occupation (dd/mm/yyyy).			

F. This is applicable for Disability Income Insurance Benefit Only.				
1) Describe the **material duties** involved in the Life Assured's occupation, beginning with the task he/she did most. The Life Assured should include all **significant** tasks that require physical mobility (e.g. lifting / carrying) and also the need to work on his/her feet for significant periods.	Details	Percentage of working hours	Details	Percentage of working hours
2) State the Life Assured's average monthly Earned Income in the 12 months before the date of Disability. Please attach documentary evidence, such as Salary Slips, Income Tax Returns, letter from employer, etc.	SGD			
3) How much of this Earned Income has been lost as a result of the Life Assured's Disability?	SGD			
4) Is the Life Assured holding more than one occupation? ❒ Yes ❒ No If "Yes", please provide details of every occupation the Life Assured held in the last twelve (12) months prior to Disability by answering the questions in Secion E, and Question 1 to 3 of Section F in a separate piece of paper .				

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F. This is applicable for Disability Income Insurance Benefit Only (continue)

5) If the Life Assured was **not** gainfully employed at the time of Disability, please advise the following:

a) Date the Life Assured commenced work in the **last** occupation. (dd/mm/yyyy)

b) Date the Life Assured **stopped** work in the last occupation. (dd/mm/yyyy)

c) State the Life Assured's last occupation and describe his/her job duties.

6) If as a result of the Life Assured's disability, he/she has not been able to follow his/her regular occupation full-time, is he/she now working part-time or in another occupation? ❒ Yes ❒ No

If "Yes", please state:

a) Life Assured's occupation (Title and Job Duties)

b) Date the Life Assured started work (dd/mm/yyyy)	c) Salary Per month (SGD)

7) Please provide particulars of any benefit, salary or remuneration the Life Assured is receiving *or* the Life Assured expects to receive because of *or* during his/her disability from employer *or* from any other insurance company or source.

Source	Amount and Frequency of Payment	Date Payment Starts	Date Payment Ceases (dd/mm/yyyy)
	S$ per		
	S$ per		

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G. DECLARATION ON BENEFICIAL OWNER (please tick (√) the box as appropriate)

I/We declare that:

❒ there is no beneficial owner under this Policy.

❒ there is/are beneficial owner(s) under this Policy. (If you tick this box, please complete the table below*.)

*The following person(s) is/are the beneficial owner(s). A copy of each of the identity card(s)/passport(s) of the beneficial owner(s) is enclosed.

Name	NRIC/FIN/Passport No.	Relationship with Policyholder

"Beneficial owner" means the natural person who ultimately owns or controls the customer or the natural person on whose behalf business relations are established, and include any person who exercises ultimate effective control over a legal person or legal arrangement.

H. DECLARATION OF US PERSON STATUS UNDER THE FOREIGN ACCOUNT TAX COMPLIANCE ACT (FATCA)

Note: US Indicia means a US citizen or resident; born in US; have a US taxpayer ID number; current US mailing or residence address (including a US post office box); current US telephone number; currently give standing instructions to transfer funds to an account maintained in the US; currently give effective power of attorney or signatory authority granted to a person with a US address; or have a US "in-care-of" or "hold mail" address).

Please tick (√) the box as appropriate.

❒ I/We declare and agree that there is no change to my tax status and I am/we are not a "US Person" for US federal income tax purposes and that I am/we are not acting for, or on behalf of a US person. I/We understand that Aviva Ltd, believing this statement to be true, will rely and act on it.

❒ I/We declare and agree that I/We have one or more US indicia but I am/we are not a "US Person" for US federal income tax purposes and that I/We am/are not acting for, or on behalf of a US person. I/We understand that Aviva Ltd, believing this statement to be true, will rely and act on it.

(If you have selected this option, please complete W-8BEN/W-8BEN-E or W-9 Form (whichever is applicable) and submit to Aviva Ltd. The forms can be found at http://www.aviva.com.sg/fatca/resources-downloads.html)

❒ I/We declare and agree that I am/we are a "U.S. Person" for U.S. federal income tax purposes.

(If you have selected this option, please complete W-9 Form and submit to Aviva Ltd. The forms can be found at http://www.aviva.com.sg/fatca/resources-downloads.html)

I/We understand that Aviva Ltd is required to provide to any governmental authority including the Inland Revenue Authority of Singapore (IRAS) and/or the US Internal Revenue Service (IRS), with information on US persons who may have received proceeds under cash value insurance contracts or annuity contracts with certain prescribed amount at any time during the calendar year. I/We agree that if my/our tax status has changed to a US tax status and/or I/we have become US citizen(s) or resident(s), I/we will notify Aviva Ltd within 30 days of the change.

I. DECLARATION OF TAX RESIDENCY UNDER THE COMMON REPORTING STANDARD (CRS)

Please tick (√) the box as appropriate.

❒ I/We declare that there is no change to the information that I/we have provided to Aviva Ltd that would result in a change to my/our tax residency status, such as change in my/our residence/mailing/in-care of address and telephone number.

❒ I/We declare that there is a change(s) to the information that I have provided to Aviva Ltd that would result in a change to my/our tax residency status, such as change in my/our residence/mailing/in-care of address and telephone number

(If you have selected this option, please complete the CRS Self-Certification Form for Individual/Entity/Controlling Person (whichever is applicable) and submit to Aviva Ltd. The forms can be found at http://www.aviva.com.sg/crs

I/We declare that I am/we are the Account Holder (or am authorized to sign the Account Holder) of all account(s) to which to this form relates. I/We undertake to notify Aviva Ltd within 30 days of any change in circumstances which affect my/our tax residency status or cause the information contained herein to become incorrect or incomplete, and to provide Aviva Ltd a suitably updated self-certification form and declaration within 90 days of such change in circumstances.

For the purposes of this section, Account Holder means the person listed or identified as the policy owner of the policy. A person holding a policy for the benefit of another person as an agent, custodian, nominee, signatory, advisor, intermediary or as a legal guardian is not treated as the Account Holder.

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J. DECLARATION AND AUTHORISATION

I/We, hereby declare that the answers given by me/us in this Form are in every respect true and correct and that no material information or circumstance has been withheld or omitted.

I/We, declare that I/We am/are not an undischarged bankrupt. There are currently no actual or pending bankruptcy proceedings against me/us and I/We have not assigned the Policy to any other party.

I/We further consent to Aviva Ltd seeking information from any clinic, hospital, doctor, person, organisation, employer that may be required in connection with this claim and I/We authorise the giving of such information to Aviva Ltd. A photocopy of this authorisation shall be considered as effective and valid as the original.

I/We consent to Aviva Ltd (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 Ltd.

I/We also consent to Aviva Ltd (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.

I/We confirm that I/we have read and agree to the terms of the Aviva Data Protection Policy (as amended, supplemented or substituted by Aviva Ltd from time to time) at 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.

Signature / thumbprint			Date (dd/mm/yyyy)
Name of Assured			
NRIC/FIN/PP No.		Mobile No.	
Email		Home Tel No.	
Residential Address			
		Country	Postal Code
Mailing Address (if different from Residential Address)			
		Country	Postal Code
Signature of Life Assured who is 21 years old or above (if different from Assured)			Date (dd/mm/yyyy)
Name of Life Assured			
NRIC/FIN/PP No.		Mobile No.	
Email		Home Tel No.	

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