



AVIVA LTD

4 Shenton Way #01-01 SGX Centre 2, Singapore 068807
Telephone: 6827 7988 Fax: 6827 7900 Company Reg. No. 196900499K

**TOTAL AND PERMANENT DISABILITY &/OR TERMINAL ILLNESS CLAIM
CLAIMANT'S STATEMENT**

POLICY NO.:

CLAIMS PROCEDURE

1. Life 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.
2. The medical reports fees (if any) will be borne by the Life Assured.
3. Please continue to pay your premium until we have informed you the outcome of your claim. We advise that Aviva Ltd does not admit liability by the mere issue of this or any other form.

1. DETAILS OF LIFE ASSURED

Name of Assured: NRIC No.:.....

Name of Life Assured: NRIC/Birth Cert No.:.....
(if different from Assured)

Date of Birth:..... Sex:..... Marital Status:

Home Address: Tel (H):

..... Mobile No.:

2. DETAILS OF LIFE ASSURED'S OCCUPATION

	Before Disability / Illness	After Disability / Illness
(a) Occupation:
(b) Name of employer:
(c) Average monthly income: for one year
(d) List exact duties performed: at work (see Note below)

(e) Date of Employment:

NOTE: If the Life Assured is **not** gainfully employed, please provide a list of **daily activities** before and after the Disability / Illness.

Before Disability / Illness:.....

.....

After Disability / Illness:.....

.....

3. DETAILS OF DISABILITY / ILLNESS

- (a) Date the symptoms of the Disability / Illness First started:
- (b) Describe the symptoms presented:

- (c) Date Life Assured First consulted a doctor for the Disability / Illness:
- (d) Diagnosis:
- (e) Date Life Assured was told of the diagnosis:
- (f) Has Life Assured previously suffered from or received treatment for a similar or related Disability / Illness?
YES / NO If "Yes", please furnish full details.

- (g) Is the Disability / Illness a result of an accident? YES / NO If "Yes", please advise:
 - (i) Date / time of accident:
 - (ii) Describe in detail how the accident happened:

 - (iii) Nature and extent of Injuries:

 - (iv) Was the accident report to the police? YES / NO If "Yes", please enclose the police report.
- (h) Date the Life Assured LAST Worked:
- (i) Is the Life Assured currently confined to: bed house neither
- (j) Date the Life Assured returned to work
- (k) Date the Life Assured expected to return to work

4. DETAILS OF DOCTOR(S) CONSULTED OR HOSPITAL(S) ADMITTED FOR THIS DISABILITY / ILLNESS

Name of Doctor	Name & Address of Clinic/Hospital	Date of First / Last Consultation
.....
.....
.....
.....

5. DETAILS OF LIFE ASSURED'S DOCTOR(S) CONSULTED FOR ANY OTHER DISORDERS IN THE PAST THREE (3) YEARS

Name of Doctor	Name & Address of Clinic/Hospital	Reason for Consultation
.....
.....
.....
.....

6. OTHER INSURANCE

Is the Life Assured claiming from any other insurer(s) or other sources in respect of this Disability / Illness? **YES / NO**
 If "Yes", please provide following information:

Name of Insurer	Policy Effective Date	Sum Assured	Type of Plan
.....
.....
.....
.....

7. DECLARATION AND AUTHORISATION

I,(NRIC/PP No.) declare that the answers given by me in this Form are in every respect true and correct and that no material information has been withheld nor any relevant circumstances omitted.

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

Signature of Witness:	Signature of Life Assured:
Name of Witness:	Name of Life Assured:
NRIC No.:	NRIC No.:
Address:	Address:.....
.....
Contact No:	Contact No:
Date:	Date:



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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 No.: _____
(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 photocopy copy of this authorization form shall be considered as effective and valid as the original.

Signature of Patient
(if Patient is above 21)

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

Name : _____

Name : _____

Address : _____

Address : _____

NRIC No. : _____

NRIC No. : _____

Date : _____

Date : _____

Relationship to
Patient : _____