* C L A I M F *

Singlife with AVIVA

PERSONAL ACCIDENT CLAIM – CLAIMANT'S STATEMENT

IMPORTANT:

1. Please read the instruction on "**How to file a Personal Accident Claim**" before completing this form.
2. All items must be duly completed to avoid delay in the claim processing. Please indicate as "N.A." if not applicable.
3. The acceptance of this form is not an admission of liability on the part of Singapore Life Ltd. Any documentary proof or report required by Singapore Life Ltd. shall be furnished at the expense of the claimant(s).
4. Mobile number and email address provided under Section J of this form will replace our Individual Life & Health policies records accordingly.
5. If you have submitted medical reimbursement claims via on-line portal or email, please keep your original bills for at least 6 months.

Policy Number			
A. Details of Life Assured/Insured Person			
Full Name		NRIC / FIN / Passport/ Birth Certificate No.	
Occupation		Date last at work (dd/mm/yyyy)	
Name and address of employer			

B. Details of Accident	
1) Date & Time of Accident (dd/mm/yyyy): (time):	2) Place & Country of Accident
3) Describe and provide details on how the accident happened, exact area(s) of the body and extent of injuries/disabilities sustained	
4) Was there any eyewitness to the accident? If "Yes", please provide details below: ❒ Yes ❒ No	

Name of Witness	Address & Contact Number	Relationship with Life Assured / Insured Person (if any)

5) Was the accident reported to the Police? ❒ Yes ❒ No If "Yes", please provide copy of the police investigation report and complete the following:	
Name of Investigation Officer-in-charge	Police Station (Branch & Address)
6) Please state the type of treatment(s) provided.	
7) Date of 1st treated (dd/mm/yyyy)	
8) For Traditional Chinese Medicine (TCM), please provide details below:	
Name of the TCM Physician	TCMB registration number:

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B. Details of Accident (continue)

9) Please state the reason if you did not seek treatment immediate after the accident.

C. Details of Injury / Illness / Infectious Disease

1) Date symptoms 1st started (dd/mm/yyyy)	2) Date 1st treated (dd/mm/yyyy)

3) Describe all the symptoms presented and the nature of the medical condition or disability.

4) Date 1st consulted doctor for the condition (dd/mm/yyyy)

5) Name & Address of doctor 1st consulted			
6) Date of diagnosis (dd/mm/yyyy)		7) Exact Diagnosis	

8) Have you suffered from or received treatment for a similar or related injury / illness / infectious disease? ❒ Yes ❒ No

If "Yes", please provide full details including name and address of doctor consulted and date of consultations, etc.

D. Other Information

1) Period of Hospitalisation (dd/mm/yyyy) **Please provide copy of hospital bill.**	From	To
2) Period of Medical Leave given (dd/mm/yyyy)	From	To
3) Period of Medical Leave for **Light Duties** given (dd/mm/yyyy)	From	To

4) Was surgery performed? If "Yes" please provide the details below: ❒ Yes ❒ No

Type of Surgical Operation / Procedure	Date of Operation / Procedure (dd/mm/yyyy)	Name & Address of Doctor / Hospital

5) Have you returned to work? ❒ Yes ❒ No

If "Yes", when did you return to work? (dd/mm/yyyy)

If "No", when would you be expected to return to work? (dd/mm/yyyy)

6) Are you able to perform all duties of your work after the accident/illness? ❒ Yes ❒ No

If "No", please provide the details below:

What are the work duties you are unable to perform?

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7) When are you expected to be able to fully perform all work duties? (dd/mm/yyyy)

8) Details of Life Assured/Insured Person's doctor(s) consulted for **this injury/illness or any other disorders / conditions**:

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

9) Are you claiming Medical Expenses, Workman's Compensation from any other source? ❒ Yes ❒ No

If "Yes", please provide the details below:

Name of Insurance Company, Employer, Third Party, etc	Nature of Claim	Amount Claimed	Policy Number

E. Policyholder's (Assured's) Bank Account Details – Default payment method is direct credit to the account below (Applicable for Individual Life and Corporate Policies only)

Name of Bank Account Holder(s)

Name of Bank	SWIFT/BIC Code	Bank Account No.

Mode of Payment (Applicable for General Insurance Only)

Please make the claim payment by the following mode:

❒ Paynow (Received payment within 3 working days) ❒ Cheque (Received payment within 10 working days)

Notes:

(i) Please provide **a copy of your bank statement/bank book** for account verification and a copy of NRIC/Passport of **all** bank account holders.

(ii) All future claims under this Policy will be paid to the above bank account, where applicable. If there is a change of bank account, please notify us.

F. This Section is for Corporate Policyholders Only

1) Name of Employer/Policyholder

2) If Sum Assured is Based on Salary, please provide a certified true copy (by employer) of the Insured Member's last pay slip (for last 3 months).

a. Last Drawn Salary		b. Date of Last Drawn Salary (dd/mm/yyyy)	
c. Date of Employment (dd/mm/yyyy)			
d. Commencement Date of Insurance for Insured Member (dd/mm/yyyy)			
e. If Deceased is a dependent, effective date of his/her insurance (dd/mm/yyyy)			

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G. This Section is applicable for Individual Life and General Insurance Only

Mobility Aid and Ambulance Services Reimbursement

1) Please list the following details for each item you are claiming for:

Description of Item including Make & Model / Service engaged	Purchase / Service Activation Date (dd/mm/yyyy)	Purchase / Activation Location	Receipts Attached (Yes / No)	Amount you are claiming for (SGD)

H. This Section is application for General Insurance Only - Personal Liability

1) Please note that any correspondence you receive regarding this incident should be sent to us immediately.

2) Was the accident due to carelessness, or negligence on your part? ❒ Yes ❒ No

3) Have you in any way admitted liability? ❒ Yes ❒ No

4) If any, which Police Officer and Police Station did you report this occurrence?

5) Names & Address(es) of the other party / parties

6) Nature of the personal injury sustained by any person

7) Extend of the damage to the property belonging to the other party / parties

8) If a claim has been made upon you, was the amount of such claim specified? ❒ Yes ❒ No

If "Yes", what is the amount:

9) Please give additional information, which you consider would help us in dealing with any claim that may be made against you.

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I. This section is Applicable for Individual Life Policy only

Declaration of Beneficial Owner (Applicable for Individual Life Policy only)

Note: This is only applicable if the recipient of the proceeds is a legal person or a legal arrangement.

❒ I/We declare that there is no change in Beneficial Owner(s).

Otherwise, please submit the Declaration of Beneficial Owner Form together with this form if there is any change in the Beneficial Ownership. You may find the Declaration of Beneficial Owner Form in our website www.singlife.com.

"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 includes any person who exercises ultimate effective control over a legal person or legal arrangement.

"Legal person" means an entity other than a natural person that can establish a permanent customer relationship with a financial institution or otherwise own property.

"Legal arrangement" means a trust or other similar arrangement.

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 Singapore Life 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 Singapore Life Ltd., believing this statement to be true, will rely and act on it.

(If you have selected this option, please complete the **United States of America (US) Person Declaration form** (available at www.singlife.com/fatca) and return to us.

❒ 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 the **United States of America (US) Person Declaration form** (available at www.singlife.com/fatca) and return to us.

I/We understand that Singapore Life 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 Singapore Life Ltd. within 30 days of the change.

Warning: Please note that providing false or misleading information is an offence under the Singapore Income Tax Act (Chapter 134).

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 Singapore Life 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 Singapore Life 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, the **CRS Self-Certification Form for Individual/Entity/Controlling Person (whichever is applicable)** (available at www.singlife.com/CRS) and return to us.

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 Singapore Life 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 Singapore Life 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.

Warning: Please note that providing false or misleading information is an offence under the Singapore Income Tax Act (Chapter 134).

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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 agree that:

a) this claim signifies my/our consent to Singapore Life Ltd. to obtain medical information from any doctor whom the Life Assured has consulted and I/We authorise the doctor to release such information to Singapore Life Ltd.
b) Singapore Life Ltd. may release any relevant information concerning the Life Assured (including medical information) to any third party, which Singapore Life Ltd. deems necessary.
c) any third party who has received any information concerning the Life Assured 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 the Life Assured (including medical information) to any other party for any purposes related to the Life Assured's application or my/our claim for the benefits.
d) a photocopied copy of this form shall be treated as valid and binding as if it is the original.

I/We declare and undertake that I/We have submitted the actual bills and receipts (including electronic/digital copies) issued by the medical institutions.

I/We understand that Singapore Life Ltd. has the right to:

a) ask for originals/certified true copies of the bills and receipts, or contact the medical institution directly, to confirm that the bills and receipts are original.
b) reject claims, recover amounts paid or impose additional charges, if the claim is false or where there are multiple claims made.

I/We consent to Singapore Life Ltd. ("Singlife") (and Singlife 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 Singlife.

I/We also consent to Singlife (and Singlife related group of companies) disclosing and transferring my/our personal data to Singlife (and Singlife related group of companies) and their respective third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

I/We have read and understood Singlife's Data Protection Notice which may be found at www.singlife.com/pdpa. Singlife's Data Protection Notice may be updated from time to time without notice. I am aware that I should visit your website regularly to ensure that I am well informed of the updates.

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. Further, you understand that you will be responsible to Singlife for any loss or claim arising out of your failure to obtain consent of the person who you have disclosed.

Signature / thumbprint & Company's Stamp (if applicable)	Date (dd/mm/yyyy)
Name of Assured/Policyholder	
NRIC/FIN/PP No.	Mobile No. *
Email *	Home/Office Tel No.
Residential Address Country	Postal Code
Mailing Address (if different from Residential Address) Country	Postal Code
Signature of Life Assured/Insured Person who is 21 years old or above (if different from Assured/Policyholder)	Date (dd/mm/yyyy)
Name of Life Assured/Insured Person	
NRIC/FIN/PP No.	Mobile No. *
Email *	Home/Office Tel No.

*** Note:** Mobile number and email address provided under this Section will replace our Individual Life & Health policies records accordingly.

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K. Declaration & Authorization (Applicable for General Insurance Only)

❒ I declare that the information provided is, to the best of my knowledge, correct in every detail. I agree that if I have made any false or fraudulent statements or suppress, conceal or falsely state any material facts whatsoever, either now, or in the future, with regard to this claim, the Policy shall be void and all rights of recovery in respect of past or future claims, shall be forfeited.

I/We consent to Singapore Life Ltd. ("Singlife") (and Singlife 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 Singlife.

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❒ I hereby authorise any hospital physician, other person, who has attended or examined me, to furnish Singapore Life Ltd., or its authorised representatives, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photo static copy of this authorisation shall be considered as effective ad valid as the original.

L. Declaration & Authorization (Applicable for Corporate Policyholders only)

I/We hereby authorise Singapore Life Ltd. ("Singlife") to request from any hospital, physician, person or organisation, all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records concerning the patient at any time and authorise the prior mentioned organisations to disclose all such information to Singlife. A photocopy of this authorisation shall be considered as effective and valid as the original.

I/We hereby authorise Singlife to request from any hospital, physician, person or organisation, all information with respect to any.

I/We declare and undertake that I/we have submitted the actual bills and receipts (including electronic/digital copies) issued by the medical institutions.

I/We understand that Singlife has the right to:

- Ask for originals/certified true copies of the bills and receipts, or contact the medical institution directly, to confirm that the bills and receipts are original.
- Reject claims, recover amounts paid or impose additional charges, if the claim is false or where there are multiple claims made.

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

I/We consent to Singapore Life Ltd. ("Singlife") (and Singlife 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 Singlife.

I/We also consent to Singlife (and Singlife related group of companies) transferring my/our personal data to Singlife (and Singlife related group of companies) and their respective third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

I/We have read and understood Singlife's Data Protection Policy which may be found at www.singlife.com/pdpa. Singlife's Data Protection Notice may be updated from time to time without notice. I/We am/are aware that I/we should visit your website regularly to ensure that I/we am/are well informed of the updates.

Name of Claimant	NRIC No.
Address	Company's Name & Stamp
Signature of Claimant	Date (dd/mm/yyyy)

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