



CHILD ILLNESS COVER - CLAIMANT'S STATEMENT

CLAIMS PROCEDURE

1. Assured to complete the Claimant's Statement and 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 and/or any further evidence required by the Company will be borne by the Assured.
3. Aviva Ltd does not admit liability by the mere issue of this or any other form.

POLICY NUMBER: _____

Name of Child / Life Assured	NRIC/Passport/Birth Cert No.	Date of Birth	Sex
Name of Assured	NRIC/Passport/Birth Cert No.	Date of Birth	Sex

1. Describe fully the symptoms of the Life Assured's illness for which he / she consulted a doctor.

2. How long did the Life Assured have the symptoms before he / she consulted a doctor:

3. Date the Life Assured First consulted a doctor:

4. Name of doctor and address of clinic / hospital whom the Life Assured First consulted for the Illness or Injury:

5. If the Life Assured's condition was due to an **Accident**, please describe fully the extent of the Life Assured's injuries and how the accident happened.

6. If the Life Assured's condition was due to **Illness**, please describe fully the extent and nature of his / her illness.

7.
 - a. What is the diagnosis?
 - b. Date the Assured was informed of the Life Assured's diagnosis:

8. What was the treatment (including any surgery) recommended and received by the Life Assured?

9. Have your child previously suffered from or received treatment for a similar or related illness? **YES / NO** If "Yes", please provide full details.

10. Does the Life Assured suffer from any other medical condition? **YES / NO** If "Yes", please advise:
Description of Illness Date(s) Diagnosed Name of Doctor & Address of Clinic / Hospital

11. Please provide the details of any doctor whom the Life Assured has consulted within the past 2 years for any medical conditions.
Name of Doctor & Address of Clinic / Hospital Date First & Last Attendance Details of Illness Date Diagnosed

12. If the Life Assured was treated at a hospital or similar institution, please furnish the following information.
Name of Doctor & Address of Hospital / Institution Date of Admission & Discharge Reasons

13. Please provide the name and address of the Life Assured's regular doctor.
Name of Doctor:

Name & Address of Clinic / Hospital:

14. Is the Life Assured claiming from any other insurance company or other sources in respect of this illness / injury?
Yes / No If "Yes", please furnish the following information.
Name of Insurer/Source Type of Plan Issue Date Sum Assured Claim Amount

Declaration and Authorisation

I hereby 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, organization, employer that may be required in connection with this claim and I authorize the giving of such information to Aviva. A photocopy of this authorisation shall be considered as effective and valid as the original.

Signature of Assured: Signature of Child/Life Assured* :

Name of Assured : Name of Child/Life Assured :

Relationship of Assured / Claimant and Life Assured :

NRIC / PP No. : BC / NRIC / PP No. :

Address :

Contact No. : (H) (Mobile)..... Date:

Note: * Signature of Life to be Assured (If Life to be Assured is age 21 and above)



AVIVA LTD

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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:

(Name of Patient) NRIC / BC No.: _____

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 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 : _____