



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

DREAD DISEASE CLAIM – CLAIMANT’S STATEMENT

CLAIMS PROCEDURE

- 1) Assured to complete and return the Claimant’s Statement to the Claims Department. 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 Assured.
- 3) Please continue to pay the 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.

POLICY NUMBER: _____

1. Name of Life Assured	I.C./Passport/B.C. No.	Date of Birth	
Occupation:	Marital Status:	Gender:	Religion:
Name of Employer:	Date of Employment:		
2. Name of Assured (if different from Life Assured):	I.C/ Passport No:	Date of Birth	Gender:

3. Nature of Claim and Related Details.

i) Describe fully the extent and nature of Life Assured’s illness and/or injuries.

ii) Date Life Assured FIRST noticed the symptoms: (dd/mm/yyyy) _____

iii) Symptoms 1st noticed: _____

iv) Date Life Assured first consulted a medical practioner for his/her illness. (dd/mm/yyyy) _____

v) Has Life Assured previously suffered from, or received treatment for a similar or related illness? **Yes / No**

If “Yes”, please furnish full details.

vi) Date Life Assured was told of the diagnosis. (dd/mm/yyyy) _____

4. (i) Give the details of any doctor whom Life Assured has consulted in connection with Life Assured’s illness.

<u>Name of Doctor</u>	<u>Name & Address of Clinic/Hospital</u>	<u>Date of First/Last Consultation</u>
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(ii) If Life Assured was treated at a hospital or similar institution, please supply the following information.

Name of Hospital or Institution

Date of Admission

Date of Discharge / Reasons of Admission

(iii) Please provide the name and address of Life Assured's **regular** doctor (s).

Name of Doctor

Name & Address of Clinic/ Hospital

Date of First/ Last Consultation

5. Is Life Assured insured for similar benefits with any other company? **Yes / No**

If "Yes", please furnish the following information.

Name of Insurer

Type of Policy

Policy Effective Date

Sum Assured

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 authorization shall be considered as effective and valid as the original.

Signature of Assured : _____

Signature of Witness : _____

Name of Assured : _____

Name of Witness : _____

Address : _____

Address : _____

Contact No. : _____

Contact No. : _____

Date : _____

Date : _____