AVIVA LTD
4 Shenton Way #01-01, SGX Centre 2, Singapore 068807
Telephone: 6827 7988 Fax: 6827 7705

GROUP LIFE & HEALTH CLAIMS
PERSONAL ACCIDENT CLAIM FORM – CLAIMANT'S STATEMENT

POLICY NUMBER: ____

SECTION I

1) Name of Insured Member	I.C/Passport/B.C No.	Occupation	Marital Status	Date of Birth	Sex

2) Sum Assured In Respect of The Insured Member

3) Date, Time & Place of Accident (To be supported by Police Report, if any)

(a) Date & Time: (b) Place:

4) How And Where Did Accident Occur?

5) Describe Injuries Sustained:

6) When Did You Become Disabled So As To Be Prevented From Doing Any Work?

Date:

7) When Did You Return To Work?

8) Please Give Details of Any Physical Defects Or Infirmity After The Accident.

9) Have You Made Any Previous Claims For Accidental Benefits? If Yes, Please Give Details:

10) Are You Entitled Compensation From Any Other Source? If Yes, Please Furnish Source And The Amount:

11) Name And Address Of All Physicians Who Attended To Your Injuries

a) Name & Address	b) Date First Attendance	c) Illness

12) To furnish us the following documents:

(a) Original medical certificates if claim is for weekly indemnity (b) Original hospital bills if claim is for medical expenses.

13) Are You Insured For Workmen's Compensation or Personal Accident Insurance With Other Insurance Company?

YES ☐ NO ☐ If YES (a) Name of Insurance Company: ______________________ (b) Policy No. ______________

(NOTE: THIS SECTION IS FOR GROUP POLICYHOLDERS ONLY)

1) Name of Employer/Policyholder

2) If Sum Assured is Based on Salary, Please Furnish a Certified True Copy (by employer) of The Insured Member's Last Pay Slip (for a full month).

a) Last Drawn Salary: b) Date of Last Drawn Salary:

3) Date of Employment

4) Commencement Date of Insurance for Insured Member

I hereby authorise any hospital, physician, person or organization to disclose when requested to do so by Aviva Ltd, any and all information with respect to any illness, or injury, medical history, consultations, prescriptions or treatment and copies of all hospital or medical records. A photostat copy of this authorisation shall be considered as effective and valid as the original.

I certify that the above statements and answers are true and complete to the best of my knowledge and belief.

Signature of Claimant : ______________________

Name of Claimant : ______________________

NRIC No. : ______________________

Address : ______________________

____

Telephone no. : ______________________

____
Company's Stamp (For Group Policy Only)

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GROUP LIFE & HEALTH CLAIMS
PERSONAL ACCIDENT BENEFIT CLAIM FORM – PHYSICIAN'S STATEMENT

SECTION II – To be completed by Attending Physician

1) Name of Patient	I.C/Passport/B.C. No.	Occupation
2) Date of Accident	3) Place of Accident	
4) What injuries has the Patient sustained?	5) When did the Patient first consult you for this condition?	
6) Nature of Treatment rendered	7) Date of Treatment rendered	
8a) How long has the Patient been *totally or *partially disabled from engaging in or attending to usual business as the result solely of the injuries? From ____________________ to ____________________ b) How much longer do you consider such disablement will continue? From ____________________ to ____________________	9) Is the Patient's disablement associated or affected by any past illness or accident? Is so, please give details:	
10) Is surgical interference necessary or likely to become so?	11) Does the Patient still require follow-up treatments?	
12) Please state the basis of awarding incapacity after the disablement had been stabilised and no further improvement or deterioration is likely in the future.	13) Is injury likely to cause loss of use of the part injured? Yes ☐ No ☐ If yes, please specify: a) The affected part/site b) At which phalanx and on which finger/toe is the loss affected if the loss is related to finger/toe injuries.	
14) Would the loss be permanent and if so, to what extent?	15) Remarks:	

* TOTALLY DISABLED is defined as a temporary but total and continuous disablement which prevents the Insured Member from the date of accident to perform any duty pertaining to his or any occupation.

* PARTIALLY DISABLED is defined as partial disablement which prevents the Insured Member from performing all duties pertaining to his occupation but is on light duties from date of accident.

I ……………………………………………………………………………………………….the undersigned, do hereby declared that I was the physician in attendance during the last illness of …………………………………………………………………………and that the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from the Company.

Date : ______________________________

Signature : ______________________________

Professional Qualification : ______________________________

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Postal Address : ______________________________

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Clinic or Hospital Stamp