

GROUP LIFE & HEATH CLAIMS

TOTAL AND PERMANENT DISABILITY CLAIM FORM – CLAIMANT’S STATEMENT

The insurer does not admit liability by the mere issue of this form.

SECTION 1 (TO BE COMPLETED BY CLAIMANT)

POLICY NO : _____

1. PERSONAL PARTICULARS

Name of Claimant	NRIC /Passport No.	Marital Status	Date of Birth (DD/MM/YY) / /	Gender F / M
Email Address	Contact No	Occupation		
Present Address:				
Date of Employment (DD/MM/YY)		Commencement Date of Insurance (DD/MM/YY)		

2. DETAILS OF OCCUPATION

	Before Disability	After Disability
a) Occupations		
b) Name Of Employer		
c) Average Monthly Income (Please furnish copy of last payroll)		
d) List exact duties performed at work (See Note (i))		

Note :

- i) If you are not working, please provide a list of daily activities before and after the disability.
- ii) The company reserves the right to request for documentary evidence.

3. DETAILS OF DISABILITY

a) Is the disability suffered due to :	<input type="checkbox"/> illness (date of symptoms started)	<input type="checkbox"/> accident (date / time of accident)
b) Describe in details all symptoms and/or nature of injuries / disability suffered		
c) Date of last work _____	d) Are you currently confined to : <input type="checkbox"/> Bed <input type="checkbox"/> House <input type="checkbox"/> Neither	
e) Date of you returned to work _____ OR date you expect to return to work _____		

4. DETAILS OF PHYSICIAN (S) CONSULTED OR HOSPITAL (S) ADMITTED FOR THIS DISABILITY

Name (s)	Address(es)	Admission Dates

5. DETAILS OF YOUR REGULAR PHYSICIAN OR ANY OTHER PHYSICIAN(S) CONSULTED FOR ANY OTHER DISORDERS IN THE PAST THREE YEARS		
Name (s)	Address(es)	Admission Dates

6. OTHER CLAIMS		
Are you claiming from any other insurance company or other sources in respect of this disability? If yes, please provide the following information :-		
Name of Company	Amount Claimed	Policy No. (if applicable)

MEDICAL INFORMATION AUTHORISATION

This part must be signed by the patient's parent / legal guardian if the patient is below 21 years old.

I hereby authorized any hospital, physician or other person who has attended me or examined me, 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 authorization shall be considered as effective and valid as the original.

Name of Claimant : _____ Signature of Claimants : _____

Address : _____

Contact No. : _____ Date : _____

(NOTE : THIS SECTION IS FOR GROUP POLICYHOLDERS ONLY)

1) Name of 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 : _____		
_____	_____	_____
Signature of Employer	Company's Name / Stamp	Date

GROUP LIFE & HEALTH CLAIMS

TOTAL AND PERMANENT DISABILITY CLAIM FORM – PHYSICIAN'S STATEMENT

SECTION II (TO BE COMPLETED BY ATTENDING PHYSICIAN AT INSURED'S EXPENSE)

Name of Claimant	NRIC /Passport No.
PART A – PATIENT'S CONDITION	
1. CONSULTATION FOR PRESENT ILLNESS / INJUR(IES)	
a) Are you the patient's usual physician? : <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, since what date? _____	
b) When did the patient first consult you for this illness or injuries)? _____	
c) When did the patient first consult you for this illness or injuries)?	
i) Symptoms presented	_____
ii) Duration of these symptoms	_____
iii) Diagnosis	_____
iv) Was the diagnosis made known to the patient?: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? If no, why? _____	
d) If consultation was for injur(ies) please describe injuries: _____	
2. Please describe treatment, including any operations performed. _____ _____ _____ _____	
3. If the patient was referred from a clinic or hospital, please state :	
a) Name of Physician	_____
b) Name of Clinic/Hospital	_____
c) Date Referred	_____
4. Has patient been admitted to hospital before for the same illness / injur(ies)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state	
a) Date admitted	_____
b) Date discharged	_____
c) Name of hospital	_____
d) Admission No.	_____
5. Has the patient suffered or is suffering from any other disease or ailment? If so, please give details _____ _____	
a) Date he first suffered from the disease or ailment	_____
b) Name and address of Physician consulted	_____

6. Based on your assessment on the patient, please indicate below what best to describe the patient's disability status :-

- Good recovery – can lead a full and independent life with or without minimal neurological deficit.
- Moderately disabled – has neurological or intellectual impairment but independent.
- Severely disabled – conscious but totally dependent on others to get through daily activities.
- Vegetative survival.

7. Is the patient able to return to his usual occupation?

- If Yes, please elaborate when can he return to work and what is the limitation?

- If No, please elaborate to what extend does his disability prevent him from performing all the normal duties of his usual occupation? When can he return to work, what is his limitation?

What other type of occupation can the patient perform?

8. In your opinion, would the patient's condition lead to death within the next 12 months from the date of diagnosis?

9. Please provide us with any other additional information that will enable the company to assess this claim.

Signature of Physician / Surgeon

Date

Name / Designation

Name and Address of Clinic / Hospital & Stamp

PART B – ACTIVITIES OF DAILY LIVING

Please comment on whether the patient is able to perform the following activities of daily living :-

Activity	Score			
<p>Feeding</p> <p>0 = unable</p> <p>5 = need help cutting, spreading butter, etc., or requires soft diet</p> <p>10 = independent</p>	0	5	10	
<p>Bathing</p> <p>0 = dependent</p> <p>5 = independent (or in shower)</p>	0			5
<p>Grooming</p> <p>0 = needs to help with personal care</p> <p>5 = independent (face / hair / teeth / shaving (implements provided))</p>	0			5
<p>Dressing</p> <p>0 = dependent</p> <p>5 = need help but can do about half unaided</p> <p>10 = independent (including buttons, zip, laces, etc)</p>	0	5	10	
<p>Bowels</p> <p>0 = incontinent (or needs to be given enemas)</p> <p>5 = occasional accident</p> <p>10 = continent</p>	0	5	10	
<p>Bladder</p> <p>0 = incontinent or catheterized and unable to manage alone</p> <p>5 = occasional accident</p> <p>10 = continent</p>	0	5	10	
<p>Toilet Use</p> <p>0 = dependent</p> <p>5 = needs some help, but can do something alone</p> <p>10 = independent (on and off, dressing, wiping)</p>	0	5	10	
<p>Transfer (bed to chair and back)</p> <p>0 = unable, no sitting balance</p> <p>5 = major help (one or two people, physical), can sit</p> <p>10 = minor help (verbal or physical)</p> <p>15 = independent</p>	0	5	10	15

Activity	Score				
Mobility (on level surfaces) 0 = immobile or < 50 yards 5 = wheelchair independent, including corners, > 50 yards 10 = walks with help of one person (verbal or physical) > 50 yards 15 = independent (but may use any aid; for example, stick) > 50 yards	0 5 10 15				
Stairs 0 = unable 5 = needs help (verbal, physical, carrying aid) 10 = independent	0 5 10				
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> _____ Signature of Physician / Surgeon </td> <td style="width: 50%; border: none;"> _____ Date </td> </tr> <tr> <td style="width: 50%; border: none;"> _____ Name / Designation </td> <td style="width: 50%; border: none;"> _____ Name and Address of Clinic / Hospital & Stamp </td> </tr> </table>		_____ Signature of Physician / Surgeon	_____ Date	_____ Name / Designation	_____ Name and Address of Clinic / Hospital & Stamp
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