



**AVIVA LTD**

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

**PERSONAL ACCIDENT CLAIM FORM – CLAIMANT’S STATEMENT**

**CLAIMS PROCEDURE**

1. The Claimant 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 Claimant.
3. Aviva Ltd does not admit liability by the mere issue of this or any other form.

**POLICY NUMBER:** \_\_\_\_\_

1) Name of Insured Member	I.C./Passport No.	Occupation	Marital Status	Date of Birth	Religion	Sex
2) Sum Assured in respect of the Insured Member	3) Please provide the following details and provide copy of Police Report, if any: a) Date and Time of Accident: _____ b) Place of Accident: _____					
4) Describe in detail how the accident happened						
5) Nature and extent of injuries						
6) When did you become disabled so as to be prevented from doing any work?				7) When did you return to work?		
8) Please give details of your <b>current</b> physical defects or infirmities						
9) Have you made any previous claims for Accidental Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please give details.						
10) Are you entitled to compensate from any other source? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide: a) Source: _____ b) Amount Compensated: _____						
11) Name and Address of All Doctors who attended to your injuries:						
a) Name of Doctor and Name & Address of Clinic/Hospital	b) Date First and Last Attendance	c) Injuries				
12) Are you insured for Workmen’s Compensation or Personal Accident Insurance with other insurance company? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide: a) Name of Insurance Company: _____ b) Policy No. _____						
13) Please 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						

**Declaration and 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 Witness : _____	Signature of Claimant : _____
Name of Witness : _____	Name of Claimant : _____
NRIC / PP No. : _____	NRIC / PP No. : _____
Address : _____	Address/Company’s Stamp : _____
Telephone no. : _____	Telephone no. : _____
Date : _____	Date : _____

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### CLINICAL ABSTRACT APPLICATION

To : The Doctor-in-charge

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 results of investigations, etc.) whether for use in connection with litigation or for other legitimate purposes.

I agree that a photocopy or faxed copy of this authorisation 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 : \_\_\_\_\_