AVIVA

LIVING & DISABILITY BENEFIT CLAIM FORM

HOW TO FILE A LIVING & DISABILITY BENEFIT CLAIM

Dear Claimant

We're sorry to receive notice of the Life Assured's condition. To enable us to process your claim, please follow the instructions provided below:

IMPORTANT NOTES:

1. All items must be duly completed to avoid delay in the claim processing. Please indicate as "N.A." if not applicable.
2. All payment will be made via Direct Credit unless otherwise stated under the Payment Method section.
3. We reserve the right to pursue for any documents that are not mentioned above if they are deemed necessary.
4. The cost of the Doctor's Statement and/or medical evidence shall be borne by the Claimant(s).
5. For Doctor's Statement or reports to be obtained from hospitals, specific Clinical Abstract Forms may be used. Please refer to the respective hospital's website for details. For clinics, please use Aviva's Clinical Abstract Application Form.
6. For treatment and surgical procedure which occurred overseas, original documents and supporting documents can only be certified by the Notary Public of the Country where Life Assured seek treatment and undergone the surgical procedure.
7. All documents submitted must be in English. Any documents which are in foreign languages must be officially translated to English by a certified translator/interpreter.
8. Aviva Ltd is required to collect information about each person's tax residency and tax classifications under applicable tax regulations, including the Singapore Income Tax Act (Chapter 134), the Foreign Account Tax Compliance Act (FATCA) and the OECD Common Reporting Standard for Common Exchange of Financial Account Information (CRS). We are required to give this information to the Internal Revenue Authority of Singapore (IRAS), together with information relating to your policies of which you are an Account Holder, which may be shared with tax authorities of other countries. If you have any question on how to determine your tax residency status, please contact a professional tax adviser as we are not allowed to give tax advice.
9. For the purpose of Foreign Account Tax Compliance Act (FATCA), a "US Person" means:
   (a) a US citizen or resident individual,
   (b) a partnership or corporation organised in the US or under the laws of the US or any State thereof, a trust if:
      (i) a court within the US would have authority under the applicable law to render orders or judgments concerning substantially all issues regarding the administration of the trust; and
      (ii) one or more US persons have the authority to control all substantial decisions of the trust, or an estate of a decedent that is a citizen or resident of the US.

Documents Required:

1. Living & Disability Benefit Claim Form - to be completed by Assured
2. Living & Disability Benefit Claim–Doctor's Statement of the relevant benefit (to be completed by the attending doctor)
3. Clinical Abstract Application Form
4. Copy of all diagnostic reports, including resting ECGs, exercise stress test, troponin results, enzymes assays, isotope studies imaging coronary angiography, blood tests, ultrasound, biopsy, histopathology report, CT scans, other imaging studies, laboratory tests results, detailed Inpatient Discharge Summary and any relevant hospital reports that are available
5. Toxicology Report
6. Original Final hospital bill/tax invoice for Hospital Cash Benefit
7. Police Investigation Report (if any)
8. Copy of the NRIC/FIN or Passport of the Life Assured
9. Copy of the NRIC/FIN or Passport of the Assured, if different from Life Assured
10. Any other documents that support the claim (e.g. official certificate of appointment of the legal guardian of minor's beneficiary)
11. Proof of Claimant's relationship with Life Assured as follows (where applicable):

Assured	Documents required (Certified True Copy)
Spouse	Marriage Certificate of Assured
Children	Birth Certificate of Life Assured/Insured Child
Parent	Birth Certificate of Life Assured/Insured Child
Sibling	Birth Certificate of Life Assured and Assured

Submission of documents:

All claim documents can be submitted personally to Our Customer Service Centre or through the Financial Adviser Representative or intermediaries or by Post. For Claims enquiries, you can also contact our Customer Service at (65) **6827 9933** or email us at **cs_life@aviva-asia.com**

Aviva Ltd | 4 Shenton Way #01-01 SGX Centre 2 Singapore 068807 | Tel: (65) 6827 7988 | Fax: (65) 6827 7900
Website: www.aviva.com.sg | Company Reg No.: 196900499K | GST Reg.No.: MR-8500166-8

Aviva: Public

AVIVA

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/FIN/Birth Certificate 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 copy of this authorisation form shall be considered as effective and valid as the original.

Signature of Patient (if patient is above aged 21)	Signature of Next-of-Kin (if patient is below aged 21)
Name	Name
NRIC/PP No.	NRIC/PP No.
Address	Address
Date DD / MM / YYYY	Date DD / MM / YYYY
	Relationship to Patient

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LIVING & DISABILITY BENEFIT CLAIM FORM

IMPORTANT:
1. Please read page 1 "**How to file a Living & Disability Benefit Claim**" before completing this form.
2. All items must be duly completed to avoid delay in the claim processing. Please indicate as "N.A." if not applicable.
3. The acceptance of this form is **not** an admission of liability on the part of Aviva. Any documentary proof or report required by Aviva shall be furnished at the expense of the claimant(s).
4. Mobile number and email address provided under Page 9 of this form will replace our records accordingly.

Details of Policy
Please list all policy numbers you are claiming for

Type of Claim **(please tick (√) box)**

❒ Critical Illness	❒ Total & Permanent Disability
❒ Special Benefit	❒ Terminal Illness Benefit
❒ Male / Female / Child Illnesses	❒ Disability Income
❒ Child's Benefit – Development Delay	❒ Hospital Care Benefit for Mother / Child
❒ Child's Benefit – Congenital Illness	❒ Pregnancy Complications
❒ Child's Benefit – Stem Cell Treatment	❒ Child's Benefit – Outpatient Phototherapy

Details of Life Assured

Full Name				NRIC / FIN / Passport/ Birth Certificate No.	
Date of Birth	DD / MM / YYYY	Gender		Marital Status	
Occupation				Date last at work	DD / MM / YYYY
Name and address of employer					

Details of Illness/Disability

Date symptoms 1st started	DD / MM / YYYY	Describe symptoms 1st presented	
Date 1st consulted doctor for the condition	DD / MM / YYYY		
Name & Address of doctor 1st consulted			
Date of diagnosis	DD / MM / YYYY	Exact Diagnosis	

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Details of Illness/Disability (continue)			
Please provide details of doctor(s) consulted for this illness/disability:			
Name and address of Doctor(s)	Date of First consultation	Date of Last consultation	Treatment Provided
	DD / MM / YYYY	DD / MM / YYYY	
	DD / MM / YYYY	DD / MM / YYYY	
	DD / MM / YYYY	DD / MM / YYYY	

Has the Life Assured been hospitalised for condition(s) related to this illness/disability? ❐ Yes ❐ No
If "Yes", please state:

Name of Hospital	Date of Admission	Date of Discharge	Reason(s) for Hospitalisation
	DD / MM / YYYY	DD / MM / YYYY	
	DD / MM / YYYY	DD / MM / YYYY	
	DD / MM / YYYY	DD / MM / YYYY	

Is the illess a result of an **Accident**? If "Yes", please state: ❐ Yes ❐ No

Date & Time of Accident	Place & Country of Accident
DD / MM / YYYY Time	

Describe and provide details on how the accident happened.

Describe the nature and extent of injuries/disability sustained, including exact site(s) of the body.

Was there any eyewitness to the accident? If "Yes", please provide details below: ❐ Yes ❐ No

Name of Witness	Address & Contact Number	Relationship with Life Assured, if any

Was the accident reported to the Police? ❐ Yes ❐ No
If "Yes", please provide copy of the police investigation report and complete the following:

Name of Investigation Officer-in-charge	Police Station (Branch & Address)

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Details of Illness/Disability (continue)
Is the Life Assured currently confined to (please tick (√) box) ❒ Bed ❒ House ❒ Hospital ❒ Others (please specify) ____________________ Date confinement started DD / MM / YYYY
Date the Life Assured Returned to Work DD / MM / YYYY
If the Life Assured has not returned to work, please state the date he/she is expected to return to work DD / MM / YYYY
Daily Activates Before and After Illness/Disability
List the daily activities the Life Assured engaged **Before** this Illness/Disability.
List the daily activities the Life Assured engages **After** this Illness/Disability.
Please elaborate what is preventing the Life Assured from doing the daily activities he/she used to engage before this Illness/Disability.
Please provide details of doctor(s) consulted for **any other** disorders / conditions and company doctor(s) below:

Name and address of Doctor(s)	Date of First consultation	Date of Last consultation	Reason(s) for consultation
	DD / MM / YYYY	DD / MM / YYYY	
	DD / MM / YYYY	DD / MM / YYYY	

Is the Life Assured claiming from any other Insurance Company(ies) or other sources in respect of this illness?
If "Yes", please provide the details: ❒ Yes ❒ No

Name of Insurance Company	Policy Number	Nature of Plan	Date of Issue	Claim Amount	Claim Notified (Yes / No)
			DD / MM / YYYY		
			DD / MM / YYYY		
			DD / MM / YYYY		

Bank Account Details - Default payment method is direct credit to the account below

Name of Bank Account Holder(s)		Type of Account: ❒ Single ❒ Joint (Please tick box)
Name of Bank	SWIFT/BIC Code	Bank Account No.

Notes:
(i) Please provide a copy of your bank statement/bank book for account verification and a copy of NRIC/Passport of all bank account holders.
(ii) Aviva will pay to the above bank account for future claims under this Policy(ies). If there is a change of bank account, please notify Aviva.

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This section is applicable for Disability Income Insurance Benefit Only	
Details of Life Assured's Occupation (immediately before the Disability)	
Occupation (Title and Job Duties)	
Name & Address of Employer	
Employment Status (please √ box)	❒ Full-Time ❒ Part-Time ❒ Contract ❒ Temporary ❒ Unemployed

Date of Employment Started	DD / MM / YYYY	Date Last Worked	DD / MM / YYYY

Please state the Date this Disability has prevented the Life Assured totally and permanently from performing the material duties of his/her occupation.	DD / MM / YYYY

Describe the **material duties** involved in the Life Assured's occupation, beginning with the task he/she did most. The Life Assured should include all **significant** tasks that require physical mobility (e.g. lifting/carrying) and also the need to work on his/her feet for significant periods.	Details	Percentage of working hours	Details	Percentage of working hours

State the Life Assured's average monthly Earned Income in the 12 months before the date of disability. Please attach documentary evidence, such as Salary Slips, Income Tax Returns, letter from employer, etc.	SGD
How much of this Earned Income has been lost as a result of the Life Assured's Disability?	SGD

Is the Life Assured holding more than one (1) occupation? ❒ Yes ❒ No

If "Yes" please provide details of every occupation the Life Assured held in the last twelve (12) months prior to Disability by **answering all the questions** in **page 6** of this form in a separate piece of paper.

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This section is applicable for Disability Income Insurance Benefit Only (continue)

If the Life Assured was not gainfully employed at the time of Disability, please provide the following details:

a) Date the Life Assured commenced work in the **last** occupation. DD / MM / YYYY

b) Date the Life Assured **stopped** work in the last occupation. DD / MM / YYYY

c) State the Life Assured's last occupation and describe his/her job duties.

If as a result of the Life Assured's Disability, he/she has **not** been able to follow his/her regular occupation full-time, is he/she now working part-time or in another occupation? If "Yes", please state: ❒ Yes ❒ No

a) Life Assured's occupation (Title and Job Duties)

b) Date the Life Assured started work DD / MM / YYYY

c) Salary per month (SGD)

Please provide particulars of any benefit, salary or remuneration the Life Assured is receiving *or* the Life Assured expects to receive because of *or* during his/her disability from employer *or* from any other insurance company or source.

Source	Amount and Frequency of Payment	Date Payment Starts	Date Payment Ceases
	S$ per	DD / MM / YYYY	DD / MM / YYYY
	S$ per	DD / MM / YYYY	DD / MM / YYYY
	S$ per	DD / MM / YYYY	DD / MM / YYYY
	S$ per	DD / MM / YYYY	DD / MM / YYYY
	S$ per	DD / MM / YYYY	DD / MM / YYYY

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Declaration of Beneficial Owner

Note: This is only applicable if the recipient of the proceeds is a legal person or a legal arrangement.

❒ I/We declare that there is no change in Beneficial Owner(s).

Otherwise, please submit the Declaration of Beneficial Owner Form together with this form if there is any change in the Beneficial Ownership. You may find the Declaration of Beneficial Owner Form in our Aviva website www.aviva.com.sg.

"Beneficial owner" means the natural person who ultimately owns or controls the customer or the natural person on whose behalf business relations are established and includes any person who exercises ultimate effective control over a legal person or legal arrangement.

"Legal person" means an entity other than a natural person that can establish a permanent customer relationship with a financial institution or otherwise own property.

"Legal arrangement" means a trust or other similar arrangement.

Declaration of US person status under the Foreign Account Tax Compliance Act (FATCA)

Note: US Indicia means a US citizen or resident; born in US; have a US taxpayer ID number; current US mailing or residence address (including a US post office box); current US telephone number; currently give standing instructions to transfer funds to an account maintained in the US; currently give effective power of attorney or signatory authority granted to a person with a US address; or have a US “in-care-of” or “hold mail” address).

Please tick (√) the box as appropriate.

❒ I/We declare and agree that there is no change to my tax status and I am/we are not a “US Person” for US federal income tax purposes and that I am/we are not acting for, or on behalf of a US person. I/We understand that Aviva Ltd, believing this statement to be true, will rely and act on it.

❒ I/We declare and agree that I/We have one or more US indicia but I am/we are not a “US Person” for US federal income tax purposes and that I/We am/are not acting for, or on behalf of a US person. I/We understand that Aviva Ltd, believing this statement to be true, will rely and act on it.
(If you have selected this option, please complete the **United States of America (US) Person Declaration form** (available at http://www.aviva.com.sg/fatca/resources-downloads.html) and return to Aviva.

❒ I/We declare and agree that I am/we are a “U.S. Person” for U.S. federal income tax purposes.
(If you have selected this option, please complete the **United States of America (US) Person Declaration form** (available at http://www.aviva.com.sg/fatca/resources-downloads.html) and return to Aviva.

I/We understand that Aviva Ltd is required to provide to any governmental authority including the Inland Revenue Authority of Singapore (IRAS) and/or the US Internal Revenue Service (IRS), with information on US persons who may have received proceeds under cash value insurance contracts or annuity contracts with certain prescribed amount at any time during the calendar year. I/We agree that if my/our tax status has changed to a US tax status and/or I/we have become US citizen(s) or resident(s), I/we will notify Aviva Ltd within 30 days of the change.

Warning: Please note that providing false or misleading information is an offence under the Singapore Income Tax Act (Chapter 134).

Declaration of Tax Residency under the Common Reporting Standard (CRS)

Please tick (√) the box as appropriate.

❒ I/We declare that there is no change to the information that I/we have provided to Aviva Ltd that would result in a change to my/our tax residency status, such as change in my/our residence/mailing/in-care of address and telephone number.

❒ I/We declare that there is a change(s) to the information that I have provided to Aviva Ltd that would result in a change to my/our tax residency status, such as change in my/our residence/mailing/in-care of address and telephone number.
(If you have selected this option, the **CRS Self-Certification Form for Individual/Entity/Controlling Person (whichever is applicable)** (available at http://www.aviva.com.sg/CRS/resources-downloads.html) and return to Aviva.

I/We declare that I am/we are the Account Holder (or am authorized to sign the Account Holder) of all account(s) to which to this form relates. I/We undertake to notify Aviva Ltd within 30 days of any change in circumstances which affect my/our tax residency status or cause the information contained herein to become incorrect or incomplete, and to provide Aviva Ltd a suitably updated self-certification form and declaration within 90 days of such change in circumstances.

For the purposes of this section, Account Holder means the person listed or identified as the policy owner of the policy. A person holding a policy for the benefit of another person as an agent, custodian, nominee, signatory, advisor, intermediary or as a legal guardian is not treated as the Account Holder.

Warning: Please note that providing false or misleading information is an offence under the Singapore Income Tax Act (Chapter 134).

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Declaration and Authorisation	

I/We, hereby declare that the answers given by me/us in this Form are in every respect true and correct and that no material information or circumstance has been withheld or omitted.

I/We, declare that I/We am/are not an undischarged bankrupt. There are currently no actual or pending bankruptcy proceedings against me/us and I/We have not assigned the Policy to any other party.

I/We agree that:

a) this claim signifies my/our consent to Aviva Ltd to obtain medical information from any doctor whom the Life Assured has consulted and I/We authorise the doctor to release such information to Aviva.
b) Aviva may release any relevant information concerning the Life Assured (including medical information) to any third party, which Aviva deems necessary.
c) any third party has received any information concerning the Life Assured may also obtain medical information from any doctor whom I/We have consulted, and I/We authorise the doctor to release such information to the third party. The third party may also release relevant information concerning the Life Assured (including medical information) to any other party for any purposes related to the Life Assured's application or my/our claim for the benefits.
d) a photocopied copy of this form shall be treated as valid and binding as if it is the original.

On behalf of myself and the Life Assured, I/We consent to Aviva (and Aviva related group of companies) collecting, using and/or disclosing the Life Assured and my/our personal data (whether contained in this form or obtained from other sources; existing data in Aviva's record or to be collected in future) for the following purposes:

a) to issue and administer the Life Assured and my/our existing and/or new policy(ies) and/or account(s) with Aviva and such other purposes ancillary or related to the administering of the policy(ies) and/or account(s), including the processing of my/our personal data for underwriting purposes, payment of premiums (including, where applicable, the deduction of premiums due from the Medisave accounts of the Life Assured) and/or claims purposes;
b) for statistical, research, compliance, audit and regulatory purposes; and
c) to provide general information on product enhancements and services relevant to my/our needs or policies (including increasing benefits, adding riders/supplements and/or the Life Assured) as well as to provide financial advice or product recommendations to me/us, where applicable.

On behalf of myself and the Life Assured, I/We also consent to Aviva (and Aviva related group of companies) disclosing and transferring my/our personal data to (i) Aviva related group of companies and their respective third party service providers, reinsurers, suppliers and intermediaries; (ii) the Government of Singapore; (iii) statutory boards; and (iv) organisations approved by the Government of Singapore, whether located in Singapore or elsewhere, for the above purpose and such other purposes as described in Aviva's Personal Data Protection Statement ("Statement").

For a copy of the Statement and more information on Aviva's data protection policy and full details of the purpose of collection, use and disclosure of your personal data, please visit http://www.aviva.com.sg/pdpa.html

Signature / thumbprint	Date DD/MM/YYYY
Name of Assured	
NRIC/FIN/PP No.	Mobile No. *
Email *	Home/Office Tel No.
Residential Address Country	Postal Code
Mailing Address (if different from Residential Address) Country	Postal Code
Signature of Life Assured who is 21 years old or above (if different from Assured)	Date DD/MM/YYYY
Name of Life Assured	
NRIC/FIN/PP No.	Mobile No. *
Email *	Home/Office Tel No.

* **Note:** Mobile number and email address provided under this Section will replace our records accordingly

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