



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



AVIVA LTD  
Group Life & Health Claims  
4 Shenton Way, #01-01 SGX Centre 2  
Singapore 068807  
Tel: 6827 8030 Fax: (65) 6827 7705  
Company Registration No.196900499K

Name of Company: \_\_\_\_\_ Policy No: \_\_\_\_\_

**SECTION I**

1) Name of insured member		IC/Passport/BC No	
Occupation	Marital Status	Date of Birth	Gender
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 to prevent you from doing your 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 accident 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 & Address of all physicians who attended to your injuries			
a) Name & Address	b) Date of 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? <input type="checkbox"/> Yes <input type="checkbox"/> No      If YES (a) Name of insurance company _____ (b) Policy Number _____			

**(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

This part must be signed by the patient's parent / legal guardian if patient is below 21 years old.  
I/We 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/We declared that the above statements and answers are true and complete to the best of my knowledge and belief.  
I/We consent to Aviva (and Aviva related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s), my/our insurance coverage and/or managing my/our relationship with Aviva.  
I/We also consent to Aviva (and Aviva related group of companies) transferring my/our personal data to Aviva related group of companies and/or third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.  
For full details of the purposes of collection, use and disclosure of your personal data, please visit <http://www.aviva.com.sg/pdpa.html>.

Name of Claimant: \_\_\_\_\_  
NRIC No: \_\_\_\_\_  
Address: \_\_\_\_\_

Company's Name & Stamp: \_\_\_\_\_ Signature of Claimant: \_\_\_\_\_



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

AVIVA LTD  
Group Life & Health Claims  
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Singapore 068807  
Tel: 6827 8030 Fax: (65) 6827 7705  
Company Registration No.196900499K

**SECTION II – To be completed by Attending Physician**

1) Name of Patient	IC/Passport/BC 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 the 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 _____	9) Is the Patient's disablement associated or affected by any past illness or accident?  If so, please give details:	
b) How much longer do you consider such disablement will continue? From _____ to _____		
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 extend?	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: \_\_\_\_\_ Professional Qualification: \_\_\_\_\_

Postal Address: \_\_\_\_\_

\_\_\_\_\_  
Clinic/Hospital Stamp

Signature: \_\_\_\_\_