* C L A I M F *

AVIVA

BENEFIT CLAIM - CLAIMANT'S STATEMENT

IMPORTANT: Please refer to the instructions below before completing this form.

1. The Life Assured/Assured 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. Please provide a clear description of each type of check-up and its corresponding charge on the original bills/receipts.
3. Provide the **original bills/receipts** together with this completed claim form and send to Aviva Ltd, Individual Life Claim Department.
4. For Lump Sum Benefit and Hospitalization Benefit, please use "Medical Insurance Benefit Claim Form".
5. We advise that Aviva Ltd does not admit liability by the mere issue of this or any other form.
6. Mobile number and email address provided under this form will replace our records accordingly.

To be completed by the Assured

POLICY NUMBER(S):	
Type of Benefit claiming (please √ box) ❒ Annuity Medical Expense ❒ Health Screening ❒ Biennial Medical	
Name of Life Assured	NRIC/FIN/Passport No
Type / Description of Check-up	Date Incurred
Name of Doctor	Name & Address of Clinic

DECLARATION AND AUTHORISATION

I, hereby declare that the answers given by me in this Form are in every respect true and correct and that no material information or circumstance has been withheld or 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 Ltd. A photocopy of this authorisation shall be considered as effective and valid as the original.

I consent to Aviva Ltd(and Aviva related group of companies) collecting, using and/or disclosing my 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) and/or managing my relationship with Aviva Ltd.

I also consent to Aviva Ltd (and Aviva related group of companies) transferring my 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.

I confirm that I have read and agree to the terms of the Aviva Data Protection Policy (as amended, supplemented or substituted by Aviva Ltd from time to time) at http://www.aviva.com.sg/pdpa.html.

I declare that there is no change to the information that I have provided to Aviva Ltd that would result in a change to my tax residency status including but not limited to my status as a U.S. Person for U.S. federal income tax purposes, such as change in my residence/mailing/in-care of address telephone number and citizenship.

I undertake to inform Aviva Ltd in writing within 30 days of any change in circumstances which would affect my tax residency status.

Note: If you are filling up this form on behalf of another person or whereby you are disclosing personal data to us other than yours, you are required to inform such person(s) of the purpose and obtain his/her consent before submitting this form to us. Once you have submitted, you will be deemed to have obtained the necessary consent for us.

Signature of Assured …….. Date ……..

Name of Assured ……

NRIC/FIN No ……

Address ……

……

Mobile No.* ……

Email* ……

For Office Use Only:

Claim Reg No.	CL
Approved Amount	S$
Approved Date	
Approved By	

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

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