PERSONAL ACCIDENT CLAIM - CLAIMANT'S STATEMENT

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

HOW TO FILE A PERSONAL ACCIDENT CLAIM

Documents Required:

For New claim (i.e. first claim for an accident or illness):

1) Personal Accident Claim: Section 1 – Claimant's Statement
2) Personal Accident Claim: Section 2 – Doctor's Statement (to be completed by the attending doctor)
3) Clinical Abstract Application Form
4) Certified true copy of the Detailed Inpatient Discharge Summary
5) Certified true copy of any diagnostic reports, laboratory evidence and any relevant hospital reports
6) Original Medical Certificates. Else, certified true copy of all medical leave certificates by the Life Assured's employer.
7) Original final Hospital Bills / medical bills & receipts
8) Toxicology Report
9) Newspaper Clipping (if any)
10) Police Investigation Report (if any)
11) Copy of the claim settlement letter and payment voucher if there was a reimbursement of medical expenses from another insurance policies (if any)
12) Any other documents that support the claim (e.g. official certificate of appointment of the legal guardian of Life Assured who is a minor)
13) Copy of the NRIC/FIN or Passport of the Life Assured
14) Copy of the NRIC/FIN or Passport of the Policy Owner, if different from Life Assured
15) Proof of Policy Owner's relationship with Life Assured as follows (where applicable):

Policy Owner	Documents required
Spouse	Marriage Certificate of Policy Owner
Children	Birth Certificate of Life Assured
Parent	Birth Certificate of Life Assured
Sibling	Birth Certificate of Life Assured and Policy Owner

In addition, for claim under the **Mobility Aid and Home Modifications**:

16) Original tax invoices and receipts for the cost incurred
17) Doctor's written recommendation and prescription for purchase of mobility aid and/or home modifications

For Continuity and/or further claim (i.e. further submission to a previous claim):

1) Completed Personal Accident Continuity Claim – Claimant's Statement
2) Certified true copy of the Detailed Inpatient Discharge Summary
3) Certified true copy of any diagnostic reports, laboratory evidence and any relevant hospital reports
4) Original Medical Certificates. Else certified true copy of all medical certificates by the Life Assured's Employer
5) Original final Hospital Bills / medical bills & receipts
6) Copy of claim settlement letter and payment voucher if there was a reimbursement of medical expenses from another insurance policies

Please read the Important Notes on page 2 of this Form.

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

Please read the Important Notes before you complete this Form.

IMPORTANT NOTES:

1. All questions in the Claimant's Statement must be fully and truthfully answered. We reserve the right to pursue for any documents that are not mentioned above if they are deemed necessary.

2. These said documents shall be in the forms as prescribed by Aviva Ltd and shall be furnished at the expense of the Claimant(s).

3. The cost of the Doctor's Statement and/or medical evidence shall be borne by the Claimant(s).

4. 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.

5. Copies of the supporting document(s) may be certified to be true copies by our Customer Service Executives at Aviva's Customer Service Centre or a Solicitor. Please note that the original documents have to be produced for certification.

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. If the Policy has been assigned, original Assignment Deed is required.

9. All claims required documents can be submitted to Aviva Ltd through the Aviva's Distributors. Alternatively, you may submit the claim personally to our Customer Service Centre.

10. Aviva Ltd is required to collect certain 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 may be legally obliged to give the Internal Revenue Authority of Singapore (IRAS) this information, along with information relating to your policies of which you are an Account Holder, which may be shared between different countries' tax authorities. If you have any questions on how to determine your tax residency status, please contact a professional tax adviser as we are not allowed to give tax advice.

11. 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.

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CLINICAL ABSTRACT APPLICATION

To whom it may concern:

_____
_____
_____
_____

Dear Sir/Madam

Please furnish **AVIVA LTD** with a detailed medical report on:

_____ NRIC / BC _____
(Name of Patient)

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 21)

Name : _____

Address : _____

_____

_____

NRIC No : _____

Date : _____

_____
Signature of Next-Of–Kin
(if Patient is below 21)

Name : _____

Address : _____

_____

_____

NRIC No : _____

Date : _____

Relationship to Patient : _____

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* C L A I M F *

PERSONAL ACCIDENT CLAIM - CLAIMANT'S STATEMENT

IMPORTANT:

1. Please read pages 1 & 2 "**How to file a Personal Accident Claim"** before completing this form.
2. 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.
3. The Assured shall bear the cost of medical reports fees (if any).
4. Please continue to pay your premium until we have informed you the outcome of your claim.
5. Aviva Ltd does not admit liability by the mere issue of this or any other form.
6. Mobile number and email address provided under Section I of this form will replace our records accordingly.

SECTION 1 – To be completed by the Claimant

POLICY NUMBER(S):			
A. Details of Life Assured			
Name of Life Assured			
NRIC/FIN/Passport/BC No	Gender	Date of Birth(dd/mm/yyyy)	Marital Status
Occupation	Name and address of Employer		
B. Details of Assured (if different from Life Assured)			
Name of Assured			
NRIC/FIN/Passport No	Gender	Date of Birth(dd/mm/yyyy)	
C. Details of Accident			
1) Date of Accident (dd/mm/yyyy)	2) Time of Accident		
3) Place of Accident			
4) Describe in detail how the accident happened.			
5) Nature and extent of injuries or disability suffered			
6) Was the accident reported to the Police? If "Yes", please provide a copy of the police report.	❒ Yes ❒ No		
7) Please state the type of treatment(s) provided.			
8) Please state the reason if you did not seek treatment immediately after the accident.			

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D. Details of Illness / Infectious Disease	
1) Date you FIRST consulted doctor for the condition (dd/mm/yyyy)	
2) Name of Doctor and address of Hospital/Clinic FIRST consulted	
3) Describe all the symptoms presented and the nature of the medical condition or disability	
4) Date symptoms FIRST started (dd/mm/yyyy)	5) Date FIRST treated (dd/mm/yyyy)
6) Please state nature of ongoing treatment and approximate date of completion (dd/mm/yyyy)	
7) Exact diagnosis	8) Date of FIRST diagnosis (dd/mm/yyyy)
9) Have you suffered from or received treatment for a similar or related illness / infectious disease? ❒ Yes ❒ No If "Yes", please provide full details including name and address of doctor consulted and date of consultations, etc.	

E. Other information		
1) Period of Hospitalisations	From (dd/mm/yyyy)	To (dd/mm/yyyy)
2) Period of Medical Leave given	Start From (dd/mm/yyyy)	End Date (dd/mm/yyyy)
3) Period of Medical Leave for Light Duties given	Start From (dd/mm/yyyy)	End Date (dd/mm/yyyy)
4) Was surgery performed? If "Yes", please provide details below.		❒ Yes ❒ No
Surgical Operation / Procedure	Date of Operation / Procedure (dd/mm/yyyy)	Name & Address of Doctor / Hospital

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5) Have you returned to work? ❒ Yes ❒ No
If "Yes", when did you return to work? (dd/mm/yyyy)

If "No", when would you be expected to return to work? (dd/mm/yyyy)

6) Are you able to perform all duties of your work after the accident/Illness? ❒ Yes ❒ No
If "No",
(a) what are the work duties you are unable to perform

(b) when are you expected to be able to fully perform all work duties? (dd/mm/yyyy)

7) Details of doctor(s) consulted and/or hospital(s) admitted for **this Injury / Illness**

Name & Address of Doctor &/or Hospital Admitted	Date of First Consultation (dd/mm/yyyy)	Date of Last Consultation (dd/mm/yyyy)	Treatment Provided

8) Details of Life Assured's doctor(s) consulted for **any other** disorders / conditions

Name & Address of Doctor	Reason for Consultation	Treatment Provided	Date of First Consultation (dd/mm/yyyy)	Date of Last Consultation (dd/mm/yyyy)

9) Are you claiming Medical Expenses, Workman's Compensation from other sources? ❒ Yes ❒ No
If "Yes", please provide the detail below.

Name of Insurance Company, Employer, Third Party, etc	Nature of Claim	Amount Claimed	Policy Number

10) **Females Only**:
(a) Were you pregnant at the time of Accident? ❒ Yes ❒ No
(b) Was your hosptialisation related to the pregnancy? ❒ Yes ❒ No
If "Yes", please provide the following details:

Name & Address of Obstetrician/Gynecologist	Date of Consultation (dd/mm/yyyy)

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F. DECLARATION ON BENEFICIAL OWNER (please tick (√) the box as appropriate)

I/We declare that:

❒ there is no beneficial owner under this Policy.

❒ there is/are beneficial owner(s) under this Policy. (If you tick this box, please complete the table below*.)

*The following person(s) is/are the beneficial owner(s). A copy of each of the identity card(s)/passport(s) of the beneficial owner(s) is enclosed.

Name	NRIC/FIN/Passport No.	Relationship with Policyholder

"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 include any person who exercises ultimate effective control over a legal person or legal arrangement.

G. 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.

H. 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.

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I. 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 further consent to Aviva Ltd seeking information from any clinic, hospital, doctor, person, organisation, employer that may be required in connection with this claim and I/We 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/We consent to Aviva Ltd (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) and/or managing my/our relationship with Aviva Ltd.

I/We also consent to Aviva Ltd (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.

I/We confirm that I/we 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.

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 / thumbprint			Date (dd/mm/yyyy)
Name of Assured			
NRIC/FIN/PP No.		Mobile No.*	
Email*		Home 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 Tel No.	

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

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