SEVERE DISABILITY CLAIM FORM

For ElderShield, MyCare, MyCare Plus, MyLongTerm Care & MyLongTerm Care Plus

Dear Policyholder

We are sorry to learn of your disability.

In order for us to process your claim, please:

1. Complete the attached Claim Form as best as you can. If you are unable to do so, please have it completed by your immediate family member or caregiver.

2. Call the clinic to make an appointment for the severe disability assessment. Please refer to the list of appointed assessors at www.aviva.com.sg.

3. Bring along the following for the appointment:
   - Completed Claim Form
   - Completed Letter of Undertaking and Indemnity (if payee is other than the Policyholder)
   - Hospital medical records and discharge summary that you may have. Please note that this is required in order for the assessor to proceed with the assessment.
   - Medicine (if any)

4. The fee for the assessment is to be paid by you, unless waived as part of the first time assessment fee waiver for CareShield Life. Please note that this is required in order for the assessor to proceed with the assessment. You will be fully reimbursed if you meet the severe disability criteria.

5. Please submit the following documents to us:
   a) Completed Claim Form
   b) Completed Letter of Undertaking and Indemnity (if payee is other than the Policyholder)
   c) Hospital medical records and discharge summary that you may have.
   d) A copy of NRIC/Passport of the Policyholder
   e) A copy of NRIC/Passport of the Caregiver
   f) A copy of the Bank Statement or bank book for account verification and copy of all NRIC/Passport of all bank account holder(s).

Once we have received all the required documents/information, we will process your claim and inform you of the outcome as soon as possible.

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 to:

4 Shenton Way
#01-01 SGX Centre 2
Singapore 068807
Attn: Individual Life Claims

If you need help, please contact our staff at **6827 7788** 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
Aviva Ltd Company Reg No.: 196900499K GST Reg.No.: MR-8500166-8

* C L A I M F *

SEVERE DISABILITY CLAIM FORM

To be completed by the Policyholder or if he/she is unable to do so, by an immediate family member/caregiver.

Important: Please read the instructions stated on the cover page before completing this form.

Type of Claim **(please tick (√) box and state the Policy No.)**

❒ **ElderShield** Policy No. _____

❒ **MyCare** Policy No. _____

❒ **MyCare Plus** Policy No. _____

❒ **MyLongTerm Care** Policy No. _____

❒ **MyLongTerm Care Plus** Policy No. _____

1. Personal Particulars

Details of Policyholder/Life Assured

Full Name (as shown in NRIC)		NRIC / FIN / Passport/ Birth Certificate No.
Date of Birth DD / MM / YYYY	Gender ❒ Male ❒ Female	Marital Status ❒ Single ❒ Married ❒ Divorced
Nationality		Ethnic Group ❒ Chinese ❒ Indian ❒ Malay ❒ Others
Residential Address		Home Contact No.
Email #		Mobile #

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

Details of Caregiver

Full Name (as shown in NRIC)	
Relationship to Policyholder	NRIC / FIN / Passport/ UEN No.
Address	Mobile
Email	Other Contact No.

Bank Account for benefits payment once claim is admitted.

Note: For payment to third party (family member or caregiver), please complete the attached Letter of Undertaking & Indemnity.

Name of Bank Account Holder	Bank Account Number
Name of Bank	Name of Branch

Details of child aged 21 and below (Applicable to Dependant Care Benefits only)

Full Name of Youngest Child	Date of Birth DD / MM / YYYY	Place of Birth	Gender ❒ Male ❒ Female
Birth Certificate Number (please provide copy of **birth certificate of child**)	If the child is legally adopted, please state **Date of Adoption** (please provide copy of legal adoption papers) DD / MM / YYYY		

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2. Medical History

Q1 Have you ever been admitted to hospital in the last 5 years? ❒ Yes ❒ No
If "Yes", please give details of the medical conditions and when it started.

Name of Hospital	Reason for Admission	Diagnosis	Onset of condition
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY

Q2 Please state other medical conditions, if any (e.g. stroke, hypertension, heart disease, diabetes mellitus, etc), that you are suffering from.

Condition	Date of Diagnosis	Name of Doctor & Clinic	Treatment Provided
	DD / MM / YYYY		
	DD / MM / YYYY		
	DD / MM / YYYY		
	DD / MM / YYYY		

Q3 Name and address of doctors consulted in the last 5 years.

Date 1st Consulted	Date Last Consulted	Name of Doctor & Clinic	Reason for Consultation
DD / MM / YYYY	DD / MM / YYYY		
DD / MM / YYYY	DD / MM / YYYY		
DD / MM / YYYY	DD / MM / YYYY		

Q4 If disability is due to accident, please provide date of accident and attach a copy of accident report.

Date of Accident DD / MM / YYYY

If no report is available, please describe:

(a) the nature of the accident

(b) extent of injuries sustained.

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3. Activities of Daily Living

Please **tick (√)** against the box that most accurately describe the policyholder's ability.	Date Disability started
Q1 **Washing** The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means. ❒ No help is needed. ❒ Some help / supervision is needed (e.g. to wash the back, to wash hair). ❒ Needs someone to help most of the time. ❒ Not able to do at all (needs to be washed or bathed entirely by caregiver).	DD / MM / YYYY
Q2 **Dressing** The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical or medical appliances. ❒ No help is needed. ❒ Some help / supervision is needed (e.g. to button clothes, to put on trousers). ❒ Needs someone to help most of the time. ❒ Not able to do at all (needs to be dressed entirely by caregiver).	DD / MM / YYYY
Q3 **Feeding** The ability to feed oneself food after it has been prepared and made available. ❒ No help is needed. ❒ Some help / supervision is needed (e.g. to scoop food, to put food in mouth). ❒ Needs someone to help most of the time. ❒ Not able to do at all (needs caregiver to feed entirely or is tube-fed).	DD / MM / YYYY
Q4 **Toileting** The ability to use the lavatory or manage bowel and bladder function through the use of protective undergarments or surgical appliances if appropriate. ❒ No help is needed. ❒ Some help / supervision is needed (e.g. to get on or off the toilet). ❒ Needs someone to help most of the time. ❒ Not able to do at all (needs caregiver to manage diapers and/or catheter).	DD / MM / YYYY
Q5 **Mobility / Walking or Moving Around** The ability to move indoors from room to room on level surfaces. ❒ No help is needed. ❒ Some help / supervision is needed (e.g. to be supervised by someone closely in case of fall). ❒ Needs someone to help most of the time. ❒ Not able to do at all (needs to be carried).	DD / MM / YYYY
Q6 **Transferring** The ability to move from a bed to an upright chair or wheelchair, and vice versa. ❒ No help is needed. ❒ Some help / supervision is needed (e.g. to be lifted from lying position to sitting position from bed). ❒ Needs someone to help most of the time. ❒ Not able to do at all (needs to be carried).	DD / MM / YYYY

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4. Declaration and Authorisation

Note: If the policyholder has previously been assessed by a doctor to lack mental capacity*, the policyholder's appointed donee(s) / deputy(s), or caregiver if a donee(s)/deputy(s) has not been appointed, is to complete this section and sign/affix thumbprint. The mentally incapacitated policyholder need not sign off/affix thumbprint.

*A separate doctor's memo should be submitted to indicate that the policyholder lacks mental capacity, including the relevant medical reason(s).

1. I/We hereby declare that the above statements are true and complete, and I/We have not withheld any material fact from Aviva Ltd.
2. I/We declare that I/We am/are not an undischarged bankrupt or insolvent or has/have executed any deed or transfer for the benefit of creditors within the last twelve (12) months.
3. I/We agree that:
   a. this declaration shall form part of my/our application for ElderShield, MyCare, MyCare Plus, MyLongTermCare and MyLongTermCare Plus Benefits ("LTC Benefits").
   b. this claim signifies my/our consent to the Insurer to obtain medical information from any doctor whom I/We have consulted and I/We authorise the doctor to release such information to the Insurer.
   c. the Insurer may release any relevant information concerning me/us (including my/our medical information) to any third party, which the Insurer deems necessary.
   d. any third party has received any information concerning me/us 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 me/us (including my medical information) to any other party for any purposes related to my/our application or claim for my/our LTC Benefits.
   e. a photocopied copy of this form shall be treated as valid and binding as if it were the original.
4. On behalf of myself and all the Lives Assured, I/We consent to Aviva (and Aviva related group of companies) collecting, using and/or disclosing 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 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 Lives 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 Lives Assured) as well as to provide financial advice or product recommendations to me/us, where applicable.
5. On behalf of myself and all the Lives 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

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.

DD / MM / YYYY

Name of Policyholder	NRIC/Passport No.	Signature/Thumb Print of Policyholder	Date

To be completed if form is filled up by family members / caregiver	
Name family member / caregiver*	Signature of family member / caregiver*
Relationship to Policyholder	Date DD / MM / YYYY

** Please delete accordingly*

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Important Note:

1. This Letter of Undertaking and Indemnity is a legal document. Please seek legal advice if you have any enquiries. Your completion of this Form will facilitate the prompt processing of your claim.
2. Please complete this Form if payment is to be made to a Third Party.

To be Completed by Payee

TO: AVIVA LIMITED - Individual Life Claims Department

PART I: LETTER OF UNDERTAKING & INDEMNITY

I / We declare that I am / we are the main caregiver of the Policyholder, _____

_____ (Name of Policyholder) of NRIC No._____

Policy No(s). _____.

In consideration of Aviva Ltd ("the Company") agreeing or having agreed, at the Policyholder's/ my / our request to pay the benefits, which the Policyholder is entitled to under the ElderShield / MyCare / MyCare Plus / MyLongTermCare / MyLongTermCare Plus Policy ("LTC Policy"), to me / us, I / we agree and undertake as follows:

1. That I / we must first apply the LTC Policy benefits paid by the Company for the care of the Policyholder.
2. That I / we will inform the Company immediately upon becoming aware that the Policyholder recovers from the disability, which refers to the inability to perform at least 3 Activities of Daily Living or passes away.
3. That I / we will repay and LTC Policy benefits, which the Policyholder is not entitled or ceases to be entitled to, upon written demand by the Company. I / We agree and undertake that if I / we fail to make such repayment, I / we will fully indemnify the Company against any loss, damage, cost and expenses whatsoever, including any legal cost, which may be incurred by the Company as a result of my/our failing to fully repay the LTC Policy benefits or of the Company's need to enforce its rights under the Undertaking or Indemnity.
4. On behalf of myself and all the Lives Assured, I/We consent to Aviva (and Aviva related group of companies) collecting, using and/or disclosing 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 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 Lives 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 Lives Assured) as well as to provide financial advice or product recommendations to me/us, where applicable.
5. On behalf of myself and all the Lives 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").

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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.

PART II: DIRECT CREDIT AUTHORISATION

Please attach a copy of the Bank Book or Statement showing the bank's name, branch and account number and a copy of all the account holder(s)'s NRIC for our action.

I / We hereby authorise the Company to credit the Eldershield / MyCare / MyCare Plus / MyLongTermCare / MyLongTermCare Plus benefits ("LTC Policy") that are payable to the Policyholder under the LTC Policy into this account and verify my / our account with the bank.

Name of Bank Account Holder(s)	NRIC No.
Name of Bank	Name of Branch
Bank Account Number	

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Details of payee (age above 21 years old)		
Full Name (Payee)	NRIC No.	Contact No.
Address		
Signature of Payee	Relationship to Policyholder	Date DD / MM / YYYY

For homes or Institutions only (if benefits are to be made to the home or Institution)		
Name of home or institution		Address of home or Institution
Name of authorised officer	Contact No. of authorised officer	Home/Institution official stamp
Signature of authorised officer	Date DD / MM / YYYY	
Full Name of Policyholder	Signature/thumbprint of Policyholder	Date DD / MM / YYYY

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