PERSONAL ACCIDENT INSURANCE CLAIMS FORM

Personal Accident Insurance Policy Number: ____

Policyholder Name: ____

Claimant Name: ____

What is the best phone number to contact you on if we need to speak to you?: ____

What is your email address if we need to write to you?: ____

DETAILS OF ACCIDENT

Settlement to be made to Insured/Other: ☐ Insured ☐ Other

If 'Other', please specify:

____

Place of accident/injury

____

Date and time of accident/injury

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) Time: ☐☐ : ☐☐ (am/pm)

Description of accident/injury (Chronology of events - Please attach additional pieces of paper if necessary)

____

Particulars of witness to the incident

Name: ____

Contact: ____

Address: ____

____

Are there any other insurance policies covering you for this accident/injury? ☐ Yes ☐ No

If 'Yes', please give details of insurer, policy number and amount recoverable

____

PersonalAccident_ClaimsForm_Mar2015

PERSONAL ACCIDENT DEATH / PERMANENT DISABLEMENT / MEDICAL EXPENSES / DAILY HOSPITAL ALLOWANCE

Details of injured part (eg. Chin, Elbow, Ankle, etc) and type of injury (eg. Fracture, Cut, Bruise, etc)

Period of hospitalisation (if any):

Date: _ _ / _ _ / _ _ _ _ (dd/mm/yyyy) to _ _ / _ _ / _ _ _ _ (dd/mm/yyyy)

Did these injuries result in temporary / permanent disability?

☐ Permanent ☐ Temporary

Date return to employment due to Temporary Disablement (if any):

Date: _ _ / _ _ / _ _ _ _ (dd/mm/yyyy)

Have you ever suffered from this injury / illness or a similar condition before?

☐ Yes ☐ No

If 'Yes', please give the details of any consultation(s) with a doctor (Please attach additional pieces of paper if necessary)

	Date of Consultation (dd/mm/yyyy)	**Name of Doctor**	**Address of Doctor**
1.	_ _ / _ _ / _ _ _ _		
2.	_ _ / _ _ / _ _ _ _		

MOBILITY AID AND AMBULANCE SERVICES REIMBURSEMENT

Please list the following details for each item you are claiming for:

	Description of Item including Make & Model / Service engaged	Purchase / Service Activation Date	Purchase / Activation Location	Receipts Attached	Amount you are claiming for (SGD)
1.				☐ Yes ☐ No	
2.				☐ Yes ☐ No	

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Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

PERSONAL LIABILITY

Please note that any correspondence you receive regarding this incident should be sent to Aviva Ltd. immediately.

Was the accident due to carelessness, or negligence on your part?

☐ Yes ☐ No

Have you in any way admitted liability?

☐ Yes ☐ No

If any, which Police Officer and Police Station did you report the occurrence?

Names & address(es) of the other party / parties

Nature of the personal injury sustained by any person

Extent of the damage to the property belonging to the other party / parties

If a claim has been made upon you, was the amount of such claim specified?

☐ Yes ☐ No

If 'Yes', what is the amount:

Please give any additional information, which you consider would help Aviva Ltd. in dealing with any claim that may be made against you.

DOCUMENTS REQUIRED TO SUPPORT YOUR CLAIM

1. Clinical Abstract Application Form
2. Copy of Detailed Inpatient Discharge Summary and any diagnostic reports, laboratory evidence and any relevant hospital reports that are available
3. Original Medical Certificates if claim is for Indemnity. Else, copies of all medical leave certificates
4. Original Hospital Bills if claim is for Medical Expense
5. Proof of relationship if claimant is different from the policyholder (child cover)
6. Proof of employment (Disability cover)
7. Newspaper Clipping and/or Police Investigation Report (if any)
8. Death certificate, autopsy report and coroner's findings (death claim)
9. Proof of relationship between deceased and claimant (death claim)

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DECLARATION & AUTHORISATION

☐ I declare that the information provided is, to the best of my knowledge, correct in every detail. I agree that if I have made any false or fraudulent statements or suppress, conceal or falsely state any material facts whatsoever, either now, or in the future, with regard to this claim, the Policy shall be void and all rights of recovery in respect of past or future claims, shall be forfeited.

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) 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.

☐ I hereby authorise any hospital physician, other person, who has attended or examined me, to furnish Aviva Ltd., or its authorised representatives, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photo static copy of this authorisation shall be considered as effective and valid as the original.

Signature of Insured

Name of Insured:

Date: __ __ / __ __ / __ __ __ __ (dd/mm/yyyy)

Once this form is fully completed, print, sign and send it with any receipts and documents to support your claim to:

Aviva Personal Accident Claims
Aviva Ltd.
4 ShentonWay
#01-01 SGX Centre 2
Singapore 068807
www.aviva.com.sg

Note: The acceptance of this form is NOT an admissionof liability on the part of Aviva.

PERSONAL ACCIDENT INSURANCE – PHYSICIAN'S STATEMENT

ATTENDING PHYSICIAN'S STATEMENT (To be completed by attending physician)

A) Patient's particulars

Name of patient

Gender ☐ Male ☐ Female

NRIC/Passport no. Date of birth ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

B) Patient's Medical Records

When did you first saw the Patient? ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

Was the Patient referred to you? ☐ Yes ☐ No

If 'Yes', since when? ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

Reason the Patient was referred

Name and address of doctor recommending the referral

If 'No', how did the Patient come to consult at your clinic/hospital? (eg. A&E)

C) Details of Injury

Is it due to sickness or injury? ☐ Injury ☐ Sickness

If it is due to an accident, please state date of accident: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

Details of symptom(s) presented during the consultation (if treatment is due to injury, please provide details on nature and extent of injuries sustained.

What is the underlying cause of illness/injury?

Exact Diagnosis

Date of diagnosis ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

Name and address of hospital patient was admitted

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C) Details of Injury *(continued)*

Period of hospitalisation (if any):

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy), Time: ☐☐ : ☐☐ (am/pm) to

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) , Time: ☐☐ : ☐☐ (am/pm)

Date of medical leave(s)

Is this a job – related injury? If 'Yes', please provide details:

Did the injury resulted in permanent or temporary disablement?

☐ Permanent ☐ Temporary

Details of any permanent disability the patient sustained as a result of the illness/injury as well as the extent in percentage:

Date return to employment due to Temporary Disablement (if any):

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

Have the Patient ever suffered from this injury/illness or a similar condition before?

☐ Yes ☐ No

If the patient did suffer from the above, please give the details of any consultation(s) with a doctor (Please attach additional pieces of paper if necessary)

	Date of Consultation (dd/mm/yyyy)	**Name of Doctor**	**Address of Doctor**
1.	☐☐ / ☐☐ / ☐☐☐☐		
2.	☐☐ / ☐☐ / ☐☐☐☐		

Is the Patient still under your care for this condition?

☐ Yes ☐ No

D) Declaration

I hereby declare that the above answers are true to the best of my knowledge and belief.

Signature of Doctor / Address & Official Stamp of Doctor

Name of Doctor:

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

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