

PUBLIC OFFICERS GROUP INSURANCE SCHEME (POGIS) – CLAIMS PROCEDURE AT A GLANCE

Please refer to the following documents required for filing each type of claim:

A. For Death Claim

- 1) Death Claim Form (to be completed)
- 2) Certified True Copy of Death Certificate
- 3) Certified True Copy of Marriage Certificate if deceased was married
- 4) Certified True Copy of deceased's Birth Certificate and copy of deceased's parents' identity cards if deceased was not married
- 5) Certified True Copy of Claimant's identity card (front and back)
- 6) Certified True Copy of Last Intestate Will (if any)

Note: Aviva will request for the Physician Statement if there is insufficient information on the submitted documents.

Please submit the following additional documents if death cause is due to accidental events:

- 1) Police Investigation Report
- 2) Post Mortem / Autopsy Report
- 3) Toxicology Report
- 4) Coroner's Inquest

B. For Total & Permanent Disability / Partial & Permanent Disability / Terminal Illness Claim

- 1) Total & Permanent Disability / Partial & Permanent Disability / Terminal Illness Claim Form (to be completed)
- 2) Physician's Statement (to be completed by Attending Physician)
- 3) Certified True Copy of all X-ray / Laboratory tests / MRI / CT Scan Reports
- 4) Certified True Copy of Member's NRIC (front and back)

Note: Cost of the Physician's Statement and/or medical evidence shall be borne by the Member.

C. For Critical Illness / Early Critical Illness Claim

- 1) Critical Illness / Early Critical Illness Claim Form (to be completed)
- 2) Physician's Statement (to be completed by Attending Physician)
- 3) Certified True Copy of all X-ray / Laboratory tests / MRI / CT Scan Reports
- 4) Certified True Copy of Member's NRIC (front and back)

Note: Cost of the Physician's Statement and/or medical evidence shall be borne by the Member.

IMPORTANT NOTE:

- **The above are the basic documents required for filing the claim, any other additional documents required will depend on the case itself. We reserve the right to pursue for the said documents.**

Submission of claim documents:

Contact us at 6827 9939 to guide you through the claim process or email the complete set of claim documents to pogis_claims@aviva-asia.com (Note: This is applicable for claim event occurring in Singapore only).

Alternatively, please submit the complete set of claim documents to our Customer Service Counters or mail in to us at:

AVIVA LTD
Group Life & Health Claims
4 Shenton Way, #01-01 SGX Centre 2, Singapore 068807

Attention: POGIS Claims Team

PUBLIC OFFICERS GROUP INSURANCE SCHEME (POGIS)

TOTAL & PERMANENT DISABILITY / PARTIAL & PERMANENT DISABILITY / TERMINAL ILLNESS CLAIM FORM

IMPORTANT:

1. Please refer to the Claims Procedure at a Glance for documents required for submission of this claim.
2. Member 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. Member shall bear the cost of medical reports (if any).
4. Please continue to pay the premiums until we have informed you on the outcome of the claim.
5. Aviva Ltd does not admit liability by the mere issue of this or any other form.

SECTION 1 – To be completed by Member

Type of Claim (please ✓ box)			
<input type="checkbox"/> Total & Permanent Disability		<input type="checkbox"/> Partial & Permanent Disability	
<input type="checkbox"/> Terminal Illness			
A. Details of Member			
Name of Member			
NRIC/FIN/Passport/BC No.	Date of Birth	Gender	Marital Status
Mailing Address			Contact No.
Email			
B. Details of Disability/Illness			
1) Date the Member FIRST consulted doctor for the condition (dd/mm/yyyy)	2) a) Symptoms presented		b) Date symptoms FIRST started
3) Name of doctor and address of hospital/clinic			
4) Exact diagnosis	5) Date of FIRST diagnosis		
6) Has the Member previously suffered from or received treatment for a similar or related Disability/Illness? If "Yes", please provide full details.			<input type="checkbox"/> Yes <input type="checkbox"/> No
7) Is the Disability/Illness a result of an Accident? If "No", please proceed to Question 8. If "Yes", please provide details as follows:			<input type="checkbox"/> Yes <input type="checkbox"/> No
a) Date & Time of Accident:		b) Place of Accident:	
c) Describe in detail how the accident happened.			
d) Describe the nature and extent of injuries/disability sustained, including exact site(s) of the body.			
e) Was the accident reported to the Police? If "Yes", please provide a copy of the police investigation report.			<input type="checkbox"/> Yes <input type="checkbox"/> No
8) Date the Member Last worked (dd/mm/yyyy):		9) Is the Member currently confined to <input type="checkbox"/> Bed <input type="checkbox"/> House <input type="checkbox"/> Hospital <input type="checkbox"/> Others: _____	

B. Details of Disability/Illness (continue)			
10) Date the Member Returned to work (dd/mm/yyyy):		11) Date confinement started (dd/mm/yyyy):	
12) If the Member has not returned to work, date he/she is expected to return to work (dd/mm/yyyy).			
13) Details of doctor(s) consultation and/or hospital(s) admission for THIS Disability/Illness			
Name of doctor & Address of hospital/clinic	Date First & Last Consultation (dd/mm/yyyy)	Treatment Provided	
14) Has the Member been hospitalized for condition(s) RELATED to THIS Disability / Illness? If "Yes", please state:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of doctor & Address of hospital/clinic	Date of Admission & Discharge (dd/mm/yyyy)	Reasons for Hospitalisation	Treatment Provided
15) Details of Member's doctor(s) consultation for any OTHER disorders / conditions			
Name of doctor & Address of hospital/clinic	Date First & Last Consultation (dd/mm/yyyy)	Reasons for Consultation	Treatment Provided
16) Is the Member claiming from any other Insurer(s) or other sources in respect of THIS Disability / Illness? If "Yes", please provide the details.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Insurer	Type of Plan	Policy Effective Date	Sum Assured

C. Daily Activities Before and After Disability/Illness
1) List the daily activities the Member engaged Before this Disability/Illness.
2) List the daily activities the Member engages After this Disability/Illness.

3) Please elaborate what is preventing the Member from doing the daily activities he/she used to engage before this Disability/Illness.

D. Details of Member's Occupation (just before the Disability/Illness)

1) Occupation (Title and Job Duties)			
2) Name & Address of Employer			
3) Employment Status	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Contract <input type="checkbox"/> Temporary <input type="checkbox"/> Unemployed		
4) Date of Employment		5) Date Last Worked	
6) Date this Disability has totally and permanently prevented the Insured Person from performing the material duties of his/her occupation (dd/mm/yyyy).			

E. 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 has been withheld nor any relevant circumstances omitted.

I/We declared 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, physician, person, organization, employer that may be required in connection with this claim and I/We authorize the giving of such information to Aviva. A photocopy of this authorization shall be considered as effective and valid as the original.

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>.

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.

Name and signature/thumbprint of Insured Employee	NRIC/Passport number	Date (dd/mm/yyyy)
Name and signature/thumbprint of Member who is 21 years old or above (if different from Insured Employee)	NRIC/Passport number	Date (dd/mm/yyyy)

F. To be completed by the relevant Ministry / Statutory Board's Authorised HR Officer only

Name of Insured Employee	NRIC / Passport No:
Name of company	Date of Employment (dd/mm/yyyy)
Name of Authorised Officer	Contact Number/ Email address of Authorised Officer
Signature & Company Stamp	Date (dd/mm/yyyy)