Singlife

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SINGAPORE LIFE LTD.
Group Life & Health Claims
4 Shenton Way, #01-01 SGX Centre 2
Singapore 068807
Tel: 6827 8030
Company Registration No.196900499K

GROUP LIFE & HEALTH CLAIMS
PERSONAL ACCIDENT CLAIM FORM – CLAIMANT'S STATEMENT

Name of Company: _____ **Policy No:** _____

SECTION I

1) Name of insured member		**IC/Passport/BC No**	
Occupation	**Marital Status**	**Date of Birth**	**Gender**
2) Sum assured in respect of the insured member		**3) Date, Time & Place of accident (To be supported by police report, if any)** **Date & Time:** _____ **Place:** _____	
4) How and where did accident occur?			
5) Describe injuries sustained:			
6) When did you become disabled to prevent you from doing your work? Date: _____			
7) When did you return to work?			
8) Please give details of any physical defects or infirmity after the accident.			
9) Have you made any previous claims for accident benefits? If Yes, Please give details:			
10) Are you entitled compensation from any other source? If Yes, Please furnish source and the amount:			
11) Name & Address of all physicians who attended to your injuries			
a) Name & Address		**b) Date of First Attendence**	**c) Illness**

12) To furnish us the following documents:

a) Original medical certificates if claim is for weekly indemnity **b) Original hospital bills if claim is for medical expenses.**

13) Are you insured for workmen's compensation or personal accident insurance with other insurance company?

☐ Yes ☐ No **If YES, a) Name of insurance company** _____ **b) Policy Number**_____

14) Bank Account details (please attach a copy of the first page of your bank book/ bank statement)

a) Name of Account Holder(s):_____ **b) Bank account number:**_____ **c) Name of Bank:**_____

NOTE: (i) For payment of living benefits only. (ii) Payment shall not include clinic, physician and any other medical providers.
(iii) If CPF Medisave is used, the appropriate amount would be credited into the respective CPF Medisave account.

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GROUP LIFE & HEALTH CLAIMS
PERSONAL ACCIDENT CLAIM FORM – CLAIMANT'S STATEMENT

(NOTE: THIS SECTION IS FOR GROUP POLICYHOLDERS ONLY)

1) Name of Employer/Policyholder

2) If sum assured is based on salary, please furnish a certified true copy (by employer) of the insured member's last pay slip (for a full month).

a) Last drawn salary:

b) Date of last drawn salary:

3) Date of employment

4) Commencement date of insurance for insured member

I/We hereby authorise Singapore Life Ltd. ("Singlife") to request from any hospital, physician, person or organisation, all information with respect to any illness, injury, medical history consultations, prescriptions or treatment, and copies of all hospital or medical records concerning the patient at any time and authorise the prior mentioned organisations to disclose all such information to Singlife. A photocopy of this authorisation shall be considered as effective and valid as the original.
I/We declare and undertake that I/we have submitted the actual bills and receipts (including electronic/digital copies) issued by the medical institutions.
I/We understand that Singlife has the right to:

- **Ask for originals/certified true copies of the bills and receipts, or contact the medical institution directly, to confirm that the bills and receipts are original.**
- **Reject claims, recover amounts paid or impose additional charges, if the claim is false or where there are multiple claims made.**

I/We declare that the statements and answers stated are true and complete to the best of my/our knowledge and belief.
I/We consent to Singlife collecting, using and/or disclosing my/our personal data for the processing of the above transaction, such other purposes ancillary or related to the administering of my/our cover, and for statistical, research, compliance, audit and regulatory purposes.
I/We also consent to Singlife disclosing and/or transferring my/our personal data to Singlife related group of companies, third party service providers, reinsurers, suppliers and/or intermediaries (including the master policyholder's intermediaries, where applicable), whether located in Singapore or elsewhere, for the above purposes.
I/We further consent to Singlife disclosing my/our personal data to the master policyholder to verify my/our eligibility for the insurance cover and such other purposes ancillary or related to the administering of the insurance cover.
Where applicable, I/we confirm that for the personal data of other individuals (contained in this form) that I/we have disclosed to Singlife, that I/we have prior to disclosing such personal data to Singlife, obtained the appropriate consent from the individual(s) to:
(i) permit me/us to collect, use and/or disclose the individual's(s') personal data to Singlife for the above purposes;
(ii) permit Singlife to collect, use and/or disclose the individual's(s') personal data for the above purposes;
(iii) permit Singlife to disclose and/or transfer the individual's(s') personal data to Singlife related group of companies, third party service providers, reinsurers, suppliers and intermediaries (including the master policyholder's intermediaries, where applicable), whether located in Singapore or elsewhere, for the above purposes; and
(iv) permit Singlife to disclose the individual's(s') personal data to the master policyholder to verify his/her/their eligibility for the insurance cover and such other purposes ancillary or related to the administering of the insurance cover.
I/We confirm that I/we have read, understood and agree to be bound by the terms of Singlife's Data Protection Notice (which may be found on https://singlife.com/en/pdpa) as may be amended, supplemented and/or substituted by Singlife from time to time, and confirm that I/we am/are aware that the latest version of such terms (amended, supplemented and/or substituted version) will be posted on Singlife's website and such version shall bind me/us upon posting and/or where I/we continue to use the relevant products and services offered by Singlife to which such terms relate to.

Name of Claimant: _____
NRIC No: _____
Address: _____

Company's Name & Stamp:_____

Signature of Claimant:_____

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GROUP LIFE & HEALTH CLAIMS
PERSONAL ACCIDENT CLAIM FORM – PHYSICIAN'S STATEMENT

SECTION II – To be completed by Attending Physician

1) Name of Patient	IC/Passport/BC No	Occupation
2) Date of Accident	3) Place of Accident	
4) What injuries has the Patient sustained?	5) When did the Patient first consulted you for the condition?	
6) Nature of Treatment rendered	7) Date of Treatment rendered	
8a) How long has the Patient been *totally or *partially disabled from engaging in or attending to usual business as the result solely of the injuries? From _____ to _____ b) How much longer do you consider such disablement will continue? From _____ to _____	9) Is the Patient's disablement associated or affected by any past illness or accident? If so, please give details:	
10) Is surgical interference necessary or likely to become so?	11) Does the Patient still require follow-up treatments?	
12) Please state the basis of awarding incapacity after the disablement had been stabilised and no further improvement or deterioration is likely in the future.	13) Is injury likely to cause loss of use of the part injured? ☐Yes ☐No If Yes, please specify: a) The affected part/site b) At which phalanx and on which finger/toe is the loss affected if the loss is related to finger/toe injuries.	
14) Would the loss be permanent and if so, to what extend?	15) Remarks:	

* **TOTALLY DISABLED** is defined as a temporary but total and continuous disablement which prevents the Insured Member from the date of accident to perform any duty pertaining to his or any occupation.

* **PARTIALLY DISABLED** is defined as partial disablement which prevents the Insured Member from performing all duties pertaining to his occupation but is on light duties from date of accident.

I _____ the undersigned, do hereby declared that I was the physician in attendance

during the last illness of _____ and that the foregoing answers are true to the best of my knowledge

and belief and that no material fact has been concealed from the Company.

Date: _____

Professional Qualification: _____

Postal Address :_____

_____

_____
Clinic/Hospital Stamp

Signature: _____