HOW TO FILE A PERSONAL ACCIDENT CLAIM

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

IMPORTANT NOTES:

1) All items must be duly completed to avoid delay in the claim processing. Please indicate as "N.A." if not applicable.
2) We reserve the right to pursue for any documents that are not mentioned above if they are deemed necessary.
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 our Clinical Abstract Application Form.
5) 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.
6) 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.
7) If you have submitted medical reimbursement claims via on-line portal or email, please keep your original bills for at least 6 months.

Documents Required:

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

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

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

Please continue to read page 2 and 3 of this instruction.

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Company Reg.No.: 196900499K GST Reg.No.: MR-8500166-8 | Navigator Investment Services Ltd Company Reg.No.: 200103470W GST Reg.No.: 20-0103470-W

Please read pages 1, 2 & 3 "**How to file a Personal Accident Claim"**

In addition, for claim under the **Mobility Aid and Home Modifications (applicable for Individual Life & Group Policies only)**:

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

For <u>Continuity and/or further</u> 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/Insured Person'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

Additional Notes:

(A) For Individual Life Policy Only

1) All payment will be made via Direct Credit unless otherwise stated under the Payment Method section.
2) Singapore Life Ltd. is required to collect 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 are required to give this information to the Internal Revenue Authority of Singapore (IRAS), together with information relating to your policies of which you are an Account Holder, which may be shared with tax authorities of other countries. If you have any question on how to determine your tax residency status, please contact a professional tax adviser as we are not allowed to give tax advice.
3) 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.

(B) For Corporate Policy Only

For other / additional benefits claim under Group Personal Accident policy, please submit:

<u>Mobility aid upon accidental Total & Permanent Disablement</u>

1) Copy of mobility aids purchase and installation invoices

<u>Ambulance Cost</u>

1) Copy of ambulance fee invoice (transportation to hospital)

<u>Home Rehabilitation Renovation Expenses</u>

1) Copy of installation invoices

Direct Crediting to Corporate Policyholder bank account only and should apply to all subsequent claims filed under the same policy unless further changes is advised to us in writing. Please provide copy of bank statement showing bank account holder with bank account number.

Please continue to read page 3 of this instruction.

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Company Reg.No.: 196900499K GST Reg.No.: MR-8500166-8 | Navigator Investment Services Ltd Company Reg.No.: 200103470W GST Reg.No.: 20-0103470-W

Please read pages 1, 2 & 3 "**How to file a Personal Accident Claim**"

(C) For General Insurance Policy Only

1) All payment will be made via PayNow or Cheque stated under the Payment Mode section (GI).

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

For Life Claims enquiries, you can also contact our Customer Service at (65) **6827 9933** or email us at **cs_life@singlife.com.**

For Corporate Claims enquiries, you can also contact our Customer Service at (65) **6827 8030** or email **your designated account servicer or intermediaries.**

For General Insurance Claims enquiries, you can also contact our Customer Service at (65) **6827 9966** or email us at **gi_claims@singlife.com**.

* C L A I M F *

Singlife with AVIVA

PERSONAL ACCIDENT CLAIM – CLAIMANT'S STATEMENT

IMPORTANT:

1. Please read the instruction on "**How to file a Personal Accident Claim**" before completing this form.
2. All items must be duly completed to avoid delay in the claim processing. Please indicate as "N.A." if not applicable.
3. The acceptance of this form is not an admission of liability on the part of Singapore Life Ltd. Any documentary proof or report required by Singapore Life Ltd. shall be furnished at the expense of the claimant(s).
4. Mobile number and email address provided under Section J of this form will replace our Individual Life & Health policies records accordingly.
5. If you have submitted medical reimbursement claims via on-line portal or email, please keep your original bills for at least 6 months.

Policy Number			
A. Details of Life Assured/Insured Person			
Full Name		NRIC / FIN / Passport/ Birth Certificate No.	
Occupation		Date last at work (dd/mm/yyyy)	
Name and address of employer			

B. Details of Accident	
1) Date & Time of Accident (dd/mm/yyyy): (time):	2) Place & Country of Accident
3) Describe and provide details on how the accident happened, exact area(s) of the body and extent of injuries/disabilities sustained	
4) Was there any eyewitness to the accident? If "Yes", please provide details below: ❒ Yes ❒ No	

Name of Witness	Address & Contact Number	Relationship with Life Assured / Insured Person (if any)

5) Was the accident reported to the Police? ❒ Yes ❒ No If "Yes", please provide copy of the police investigation report and complete the following:	
Name of Investigation Officer-in-charge	Police Station (Branch & Address)
6) Please state the type of treatment(s) provided.	
7) Date of 1st treated (dd/mm/yyyy)	
8) For Traditional Chinese Medicine (TCM), please provide details below:	
Name of the TCM Physician	TCMB registration number:

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Company Reg.No.: 196900499K GST Reg.No.: MR-8500166-8 | Navigator Investment Services Ltd Company Reg.No.: 200103470W GST Reg.No.: 20-0103470-W

B. Details of Accident (continue)

9) Please state the reason if you did not seek treatment immediate after the accident.

C. Details of Injury / Illness / Infectious Disease

1) Date symptoms 1st started (dd/mm/yyyy)	2) Date 1st treated (dd/mm/yyyy)

3) Describe all the symptoms presented and the nature of the medical condition or disability.

4) Date 1st consulted doctor for the condition (dd/mm/yyyy)

5) Name & Address of doctor 1st consulted			
6) Date of diagnosis (dd/mm/yyyy)		7) Exact Diagnosis	

8) Have you suffered from or received treatment for a similar or related injury / illness / infectious disease? ❒ Yes ❒ No

If "Yes", please provide full details including name and address of doctor consulted and date of consultations, etc.

D. Other Information

1) Period of Hospitalisation (dd/mm/yyyy) **Please provide copy of hospital bill.**	From	To
2) Period of Medical Leave given (dd/mm/yyyy)	From	To
3) Period of Medical Leave for **Light Duties** given (dd/mm/yyyy)	From	To

4) Was surgery performed? If "Yes" please provide the details below: ❒ Yes ❒ No

Type of Surgical Operation / Procedure	Date of Operation / Procedure (dd/mm/yyyy)	Name & Address of Doctor / Hospital

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", please provide the details below:

What are the work duties you are unable to perform?

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Company Reg.No.: 196900499K GST Reg.No.: MR-8500166-8 | Navigator Investment Services Ltd Company Reg.No.: 200103470W GST Reg.No.: 20-0103470-W

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

8) Details of Life Assured/Insured Person's doctor(s) consulted for **this injury/illness or 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 any other source? ❒ Yes ❒ No

If "Yes", please provide the details below:

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

E. Policyholder's (Assured's) Bank Account Details – Default payment method is direct credit to the account below (Applicable for Individual Life and Corporate Policies only)

Name of Bank Account Holder(s)

Name of Bank	SWIFT/BIC Code	Bank Account No.

Mode of Payment (Applicable for General Insurance Only)

Please make the claim payment by the following mode:

❒ Paynow (Received payment within 3 working days) ❒ Cheque (Received payment within 10 working days)

Notes:

(i) Please provide **a copy of your bank statement/bank book** for account verification and a copy of NRIC/Passport of **all** bank account holders.

(ii) All future claims under this Policy will be paid to the above bank account, where applicable. If there is a change of bank account, please notify us.

F. This Section is for Corporate Policyholders Only

1) Name of Employer/Policyholder

2) If Sum Assured is Based on Salary, please provide a certified true copy (by employer) of the Insured Member's last pay slip (for last 3 months).

a. Last Drawn Salary		b. Date of Last Drawn Salary (dd/mm/yyyy)	
c. Date of Employment (dd/mm/yyyy)			
d. Commencement Date of Insurance for Insured Member (dd/mm/yyyy)			
e. If Deceased is a dependent, effective date of his/her insurance (dd/mm/yyyy)			

Singapore Life Ltd. 4 Shenton Way #01-01 SGX Centre 2 Singapore 068807 singlife.com
Company Reg.No.: 196900499K GST Reg.No.: MR-8500166-8 | Navigator Investment Services Ltd Company Reg.No.: 200103470W GST Reg.No.: 20-0103470-W

G. This Section is applicable for Individual Life and General Insurance Only

Mobility Aid and Ambulance Services Reimbursement

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

Description of Item including Make & Model / Service engaged	Purchase / Service Activation Date (dd/mm/yyyy)	Purchase / Activation Location	Receipts Attached (Yes / No)	Amount you are claiming for (SGD)

H. This Section is application for General Insurance Only - Personal Liability

1) Please note that any correspondence you receive regarding this incident should be sent to us immediately.

2) Was the accident due to carelessness, or negligence on your part? ❒ Yes ❒ No

3) Have you in any way admitted liability? ❒ Yes ❒ No

4) If any, which Police Officer and Police Station did you report this occurrence?

5) Names & Address(es) of the other party / parties

6) Nature of the personal injury sustained by any person

7) Extend of the damage to the property belonging to the other party / parties

8) If a claim has been made upon you, was the amount of such claim specified? ❒ Yes ❒ No

If "Yes", what is the amount:

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

Singapore Life Ltd. 4 Shenton Way #01-01 SGX Centre 2 Singapore 068807 singlife.com
Company Reg.No.: 196900499K GST Reg.No.: MR-8500166-8 | Navigator Investment Services Ltd Company Reg.No.: 200103470W GST Reg.No.: 20-0103470-W

I. This section is Applicable for Individual Life Policy only

Declaration of Beneficial Owner (Applicable for Individual Life Policy only)

Note: This is only applicable if the recipient of the proceeds is a legal person or a legal arrangement.

❒ I/We declare that there is no change in Beneficial Owner(s).

Otherwise, please submit the Declaration of Beneficial Owner Form together with this form if there is any change in the Beneficial Ownership. You may find the Declaration of Beneficial Owner Form in our website www.singlife.com.

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

"Legal person" means an entity other than a natural person that can establish a permanent customer relationship with a financial institution or otherwise own property.

"Legal arrangement" means a trust or other similar arrangement.

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 Singapore Life 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 Singapore Life 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 www.singlife.com/fatca) and return to us.

❒ 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 www.singlife.com/fatca) and return to us.

I/We understand that Singapore Life 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 Singapore Life Ltd. within 30 days of the change.

Warning: Please note that providing false or misleading information is an offence under the Singapore Income Tax Act (Chapter 134).

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 Singapore Life 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 Singapore Life 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 www.singlife.com/CRS) and return to us.

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 Singapore Life 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 Singapore Life 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.

Warning: Please note that providing false or misleading information is an offence under the Singapore Income Tax Act (Chapter 134).

Singapore Life Ltd. 4 Shenton Way #01-01 SGX Centre 2 Singapore 068807 singlife.com
Company Reg.No.: 196900499K GST Reg.No.: MR-8500166-8 | Navigator Investment Services Ltd Company Reg.No.: 200103470W GST Reg.No.: 20-0103470-W

J. 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 agree that:

a) this claim signifies my/our consent to Singapore Life Ltd. to obtain medical information from any doctor whom the Life Assured has consulted and I/We authorise the doctor to release such information to Singapore Life Ltd.
b) Singapore Life Ltd. may release any relevant information concerning the Life Assured (including medical information) to any third party, which Singapore Life Ltd. deems necessary.
c) any third party who has received any information concerning the Life Assured 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 the Life Assured (including medical information) to any other party for any purposes related to the Life Assured's application or my/our claim for the benefits.
d) a photocopied copy of this form shall be treated as valid and binding as if it is 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 Singapore Life Ltd. has the right to:

a) 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.
b) reject claims, recover amounts paid or impose additional charges, if the claim is false or where there are multiple claims made.

I/We consent to Singapore Life Ltd. ("Singlife") (and Singlife 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 Singlife.

I/We also consent to Singlife (and Singlife related group of companies) disclosing and transferring my/our personal data to Singlife (and Singlife related group of companies) and their respective third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

I/We have read and understood Singlife's Data Protection Notice which may be found at www.singlife.com/pdpa. Singlife's Data Protection Notice may be updated from time to time without notice. I am aware that I should visit your website regularly to ensure that I am well informed of the updates.

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. Further, you understand that you will be responsible to Singlife for any loss or claim arising out of your failure to obtain consent of the person who you have disclosed.

Signature / thumbprint & Company's Stamp (if applicable)	Date (dd/mm/yyyy)
Name of Assured/Policyholder	
NRIC/FIN/PP No.	Mobile No. *
Email *	Home/Office Tel No.
Residential Address Country	Postal Code
Mailing Address (if different from Residential Address) Country	Postal Code
Signature of Life Assured/Insured Person who is 21 years old or above (if different from Assured/Policyholder)	Date (dd/mm/yyyy)
Name of Life Assured/Insured Person	
NRIC/FIN/PP No.	Mobile No. *
Email *	Home/Office Tel No.

*** Note:** Mobile number and email address provided under this Section will replace our Individual Life & Health policies records accordingly.

Singapore Life Ltd. 4 Shenton Way #01-01 SGX Centre 2 Singapore 068807 singlife.com
Company Reg.No.: 196900499K GST Reg.No.: MR-8500166-8 | Navigator Investment Services Ltd Company Reg.No.: 200103470W GST Reg.No.: 20-0103470-W

K. Declaration & Authorization (Applicable for General Insurance Only)

❒ 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 Singapore Life Ltd. ("Singlife") (and Singlife 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 Singlife.

I/We also consent to Singlife (and Singlife related group of companies) disclosing and transferring my/our personal data to Singlife (and Singlife related group of companies) and their respective third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

I/We have read and understood Singlife's Data Protection Notice which may be found at www.singlife.com/pdpa. Singlife's Data Protection Notice may be updated from time to time without notice. I/We am/are aware that I/we should visit your website regularly to ensure that I/we am/are well informed of the updates.

❒ I hereby authorise any hospital physician, other person, who has attended or examined me, to furnish Singapore Life 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 ad valid as the original.

L. Declaration & Authorization (Applicable for Corporate Policyholders only)

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 hereby authorise Singlife to request from any hospital, physician, person or organisation, all information with respect to any.

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 Singapore Life Ltd. ("Singlife") (and Singlife 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 Singlife.

I/We also consent to Singlife (and Singlife related group of companies) transferring my/our personal data to Singlife (and Singlife related group of companies) and their respective third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

I/We have read and understood Singlife's Data Protection Policy which may be found at www.singlife.com/pdpa. Singlife's Data Protection Notice may be updated from time to time without notice. I/We am/are aware that I/we should visit your website regularly to ensure that I/we am/are well informed of the updates.

Name of Claimant	NRIC No.
Address	Company's Name & Stamp
Signature of Claimant	Date (dd/mm/yyyy)

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Company Reg.No.: 196900499K GST Reg.No.: MR-8500166-8 | Navigator Investment Services Ltd Company Reg.No.: 200103470W GST Reg.No.: 20-0103470-W