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Group Life & Health Claims
4 Shenton Way, #01-01 SGX Centre 2
Singapore 068807
Tel: 6827 8030 Fax: (65) 6827 7705
Company Registration No. 196900499K

MINDEF & MHA GROUP INSURANCE
TOTAL & PERMANENT DISABLEMENT / ACCIDENTAL TOTAL & PERMANENT DISMEMBERMENT / ADVANCE PAYMENT BENEFIT / INJURY DUE TO ACCIDENT / DISABILITY INCOME / COMATOSE LUMP SUM BENEFIT CLAIM FORM

IMPORTANT:

1. Please refer to the **Claims Procedure at a Glance** for documents required for submission of this claim.
2. The Insured Person/Insured Member/Insured Affiliate 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. The Insured Person/Insured Member/Insured Affiliate 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 Insured Person

Type of Claim (please √ box) ❒ Total & Permanent Disablement ❒ Accidental Total & Permanent Dismemberment ❒ Advance Payment Benefit ❒ Injury due to Accident ❒ Disability Income ❒ Comatose Lump Sum Benefit

A. Details of Insured Person

Name of Insured Person			
NRIC/FIN/Passport/BC No.	Date of Birth	Gender	Marital Status
Mailing Address			Contact No.
Email			
Name of Insured Member/Insured Affiliate Member (if different from Insured Person)	Insured Member/Insured Affiliate Member NRIC/FIN/Passport No.		

B. Details of Disability/Illness

1) Date the Insured Person FIRST consulted doctor for the condition (ddmmyyyy)	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 Insured Person previously suffered from or received treatment for a similar or related Disability/Illness? ❒ Yes ❒ No
If "Yes", please provide full details.

7) Is the Disability/Illness a result of an Accident? ❒ Yes ❒ No
If "No", please proceed to Question 8.
If "Yes", please provide details as follows:

a) Date & Time of Accident:	b) Place of Accident:
c) Describe in detail how the accident happened.	

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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? ❒ Yes ❒ No
If "Yes", please provide a copy of the police investigation report.

B. Details of Disability/Illness (continue)

8) Date the Insured Person Last worked (dd/mm/yyyy):

10) Date the Insured Person Returned to work (dd/mm/yyyy):

9) Is the Insured Person currently confined to
❒ Bed ❒ House ❒ Hospital ❒ Others:_____

Date confinement started: (ddmmyyy)_____

11) If the Insured Person has not returned to work, date he/she is expected to return to work (dd/mm/yyyy).

12) 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

13) Has the Insured Person been hospitalized for condition(s) **RELATED** to **THIS** Disability / Illness? ❒ Yes ❒ No
If "Yes", please state:

Name of doctor & Address of hospital/clinic	Date of Admission & Discharge (ddmmyyyy)	Reasons for Hospitalisation	Treatment Provided

14) Details of Insured Person's doctor(s) consultation for any **OTHER** disorders / conditions

Name of doctor & Address of hospital/clinic	Date First & Last Consultation (ddmmyyyy)	Reasons for Consultation	Treatment Provided

15) Is the Insured Person claiming from any other Insurer(s) or other sources in respect of **THIS** Disability / Illness? ❒ Yes ❒ No
If "Yes", please provide the details.

Name of Insurer	Type of Plan	Policy Effective Date	Sum Assured

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C. Daily Activities Before and After Disability/Illness

1) List the daily activities the Insured Person engaged **Before** this Disability/Illness.

2) List the daily activities the Insured Person engages **After** this Disability/Illness.

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

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

1) Occupation (Title and Job Duties)			
2) Name & Address of Employer			
3) Employment Status	❒ Full-Time ❒ Part-Time ❒ Contract ❒ Temporary ❒ 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 (ddmmyyyy).

E. This is applicable for Disability Income Insurance Benefit Only.

1. Describe the **material duties** involved in the Life Assured's occupation, beginning with the task he/she did most.

   The Life Assured should include all significant tasks that required physical mobility (e.g. lifting / carrying) and also the need to work on his/her feet for significant periods.

Details	Percentage of working hours	Details	Percentage of working hours

2. State the Insured Person's average monthly Earned income in the 12 months before the date of Disability. Please attach documentary evidence, such as Salary Slips, Income Tax Returns, letter from employer, etc.	SGD
3. How much of this Earned Income has been lost as a result of the Insured Person's Disability?	SGD

4. Is the Insured Person holding more than one occupation? ❒ Yes ❒ No

If "Yes", please provide details of every occupation the Insured Person held in the last twelve (12) months prior to Disability by answering the questions in Section D, and Question 1 to 3 of Section E in a separate piece of paper.

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5. If the Insured Person was **not** gainfully employed at the time of Disability, please advise the following:

a) Date the Insured Person commenced work in the **last** occupation (ddmmyyyy)	b) Date the Insured Person **stopped** work in the last occupation (ddmmyyyy)

c) State the Insured Person's last occupation and describe his/her job duties.

6. If as a result of the Insured Person's disability, he/she has not been able to follow his/her regular occupation full-time, is he/she now working part-time or in another occupation? **If "Yes"**, please state: ❒ Yes ❒ No

a) Insured Person's occupation (Title and Job Duties)

b) Date the Insured Person started work (dd/mm/yyyy)	c) Salary Per month (SGD)

7. Please provide particulars of any benefit, salary or remuneration the Insured Person is receiving or the Insured Person expects to receive because of or during his/her disability from employer or from any other insurance company or source.

Source	Amount	Date Payment Starts	Date Payment Ceases
	S$ per		
	S$ per		

F. Payment Mode Option

Please tick (✓) ONE of the boxes below to indicate payment mode option:

❒ Cheque

❒ Direct credit into the following claim recipient's personal individual account (please provide a **copy of the bank book or bank statement** for account verification. **Otherwise a cheque will be issued**).

Name of Bank	
Bank Account Number	
Bank Account Holder's Name	

G. DECLARATION AND CONSENT

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 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 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 further consent to Aviva Ltd and Aviva related group of companies the following:

(a) 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.

(b) 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.

I/We understand that I/we can visit http://www.aviva.com.sg/pdpa.html for the full details of the purposes of collection, use and disclosure of my/our personal data.

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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.

Signature of Insured Member /Insured Affiliate Member:.....	Signature of Insured Person:.....
Name of Insured Member /Insured Affiliate Member:.....	Name of Insured Person:.....
NRIC/FIN No:.....	NRIC/FIN No:.....
Address:.....	Address:.....
Contact No:.....	Contact No:.....
Email:.....	Email:.....
Date:.....	Date:.....