

## **MINDEF & MHA GROUP INSURANCE – CLAIMS PROCEDURE AT A GLANCE**

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

### **A. For Death Claim under Group Term Life and Group Personal Injury policy:**

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

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

### **If death cause is due to accidental events, please submit:**

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

### **B. For other / additional benefits claim under Group Personal Injury policy, please submit:**

#### **Disappearance**

- 1) Newspaper Clippings (if any)
- 2) Copy of Airline / Authorities letter confirming that deceased was a passenger of the unfortunate accident
- 3) Copy of Immigration & Checkpoints Authority (ICA) letter indicating updated life status of deceased

#### **Child Education Fund Benefit**

- 1) Copy of child's Birth Certificate (front and back)
- 2) Copy of child's Concession Pass (front and back) or Enrolment letter from Institution

#### **Compassionate Death Allowance Benefit**

- 1) Copy of funeral expenses invoices

### **C. For Total & Permanent Disablement / Total & Permanent Dismemberment due to Accident / Advance Payment Benefit / Injury due to Accident / Disability Income / Comatose Lump Sum Benefit Claim under Group Term Life and Group Personal Injury policy:**

- 1) Claim Form (to be completed)
- 2) Physician Statement (to be completed by attending physician)
- 3) Copy of all related diagnostic reports, e.g. CT Scans, MRI Scans, X-Rays, laboratory reports
- 4) Copy of Insured Person's NRIC (front and back)
- 5) Copy of Insured Member's / Insured Affiliate Member's NRIC (front and back), if Insured Person is a dependant

### **Additional documents required for Disability Income Benefit Claim:**

- 1) Employment and/or Income documents, e.g. confirmation from employer on absence from work, termination letter, pay slips, IR8A Form, CPF Statements, Commission Statement, etc.
- 2) Copies of all medical leave certificates

### **D. For other / additional benefits claim under Group Personal Injury policy, please submit:**

#### **Mobility aid upon accidental Total & Permanent Disablement**

- 1) Copy of mobility aids purchase and installation invoices

#### **Ambulance Cost**

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

**Home Rehabilitation Renovation Expenses**

- 1) Copy of installation invoices

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

**E. For Living Care / Living Care Plus Claim**

- 1) Living Care / Living Care Plus Claim Form (to be completed)
- 2) Physician Statement (to be completed by attending physician)
- 3) Copy of all related diagnostic reports, e.g. CT Scans, MRI Scans, PET Scans, X-Ray, histopathology / laboratory reports
- 4) Copy of Insured Person's NRIC (front and back)
- 5) Copy of Insured Member's / Affiliate Member's NRIC (front and back), if Insured Person is a dependant

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

**F. For Daily Hospital Cash Benefit / Hospital Recuperation Benefit / Simple Fracture or Other Fracture due to Accident Claim under Group Term Life and Group Personal Injury policy:**

- 1) Claim Form (to be completed)
- 2) Copy of finalized hospital bill (admission and discharge dates have to be indicated)
- 3) Copy of all related diagnostic reports, e.g. CT Scans, MRI Scans, PET Scans, X-Ray, histopathology / laboratory reports
- 4) Copy of Inpatient Discharge Summary / Doctor's memorandum indicating diagnosis and date of injury
- 5) Copy of Insured Person's NRIC (front and back)
- 6) Copy of Insured Member's / Insured Affiliate Member's NRIC (front and back), if Insured Person is a dependant

**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.**
- **For submission via email, please ensure that documents are colored scanned.**

**Submission of claim documents:**

To submit a claim, complete the relevant Claim Form and also have on-hand the required supporting documents. Thereafter, email us the complete set of claim documents for our claim review. We will acknowledge your electronic claim submission within 2 business days.

Alternatively, you may call us and we will be able to guide you through the claim process.

You may contact us at:

**MINDEF & MHA Claims Hotline – 6827 8030**

**Our Operating Hours:**

Mondays – Fridays 8.45am – 5.30pm

Closed on Saturdays, Sundays and Public Holidays

**Email Addresses – [MINDEF\\_Claims@singlife.com](mailto:MINDEF_Claims@singlife.com)** (For Mindef Claims)

[MHA\\_Claims@singlife.com](mailto:MHA_Claims@singlife.com) (For MHA Claims)

**MINDEF & MHA GROUP INSURANCE  
GROUP LIVING CARE / LIVING CARE PLUS 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 fees (if any).
4. Please continue to pay the premium until we have informed you on the outcome of your claim.
5. Singapore Life Ltd. does not admit liability by the mere issue of this or any other form.

**SECTION 1 – To be completed by the Insured Person**

<b>Type of Claim (please v box)</b>		<input type="checkbox"/> Living Care	<input type="checkbox"/> Living Care Plus
<b>A. Details of Insured Person</b>			
Name of Insured Person			
NRIC/FIN/Passport/BC No	Date of Birth	Marital Status	Gender Religion
Mailing Address			Contact No.
Email			
Name of Insured Member/Insured Affiliate Member (if different from Insured Person)	NRIC/FIN/Passport/BC No	<input type="checkbox"/> Yes <input type="checkbox"/> No <small>(applicable to MINDEF only)</small>	
<b>B. Details of Illness</b>			
1) Date symptom 1 <sup>st</sup> started		2) Describe symptoms 1 <sup>st</sup> presented	
3) Date 1 <sup>st</sup> consulted doctor for the condition			
4) Name & Address of doctor 1 <sup>st</sup> consulted			
5) Date of diagnosis		6) Exact diagnosis	
7) What was the treatment (including any surgery) recommended and received by you?			
8) Have you previously suffered from or received treatment for a similar or related illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide full details.			

<b>B. Details of Illness (continue)</b>			
9) Is the Illness a result of an Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please state			
Date & Time of Accident		Place of Accident	
Describe in detail how the accident happened			
Nature and extent of injuries			
Was the accident reported to the Police? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide a copy of the police report.			
10) Details of doctor(s) consulted or hospital(s) admitted for this Illness			
Name & Address of Doctor	Date 1 <sup>st</sup> & Last Consulted	Treatment Provided	
11) Details of doctor(s) consulted for any other disorders / conditions			
Name & Address of Doctor	Reason for Consultation	Treatment Provided	Date 1 <sup>st</sup> & Last Consulted
12) Have Insured Person been hospitalized for condition(s) related to your Illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please state			
Name of Hospital	Date of Admission	Date of Discharge	Reason for Hospitalization
13) Is Insured Person claiming from any other Insurer(s) or other sources in respect of this Illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide the details.			
Name of Insurer	Type of Plan	Policy Effective Date	Sum Assured

<b>C. Payment Mode Option</b>	
Direct credit into the following claim recipient's personal individual account (please provide a <b>copy of the bank book or bank statement</b> for account verification).	
Name of Bank	
Bank Account Number	
Bank Account Holder's Name	

<b>D. DECLARATION AND CONSENT</b>	
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 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.	
<ul style="list-style-type: none"> <li>On behalf of myself and all proposed insured lives, I/we consent to Singlife disclosing and transferring my/our personal data to a new insurer selected by MINDEF or MHA for the purpose of facilitating and/or administering insurance coverage with the new insurer.</li> </ul>	
I/We have read and understood Singlife's Data Protection Notice which may be found at <a href="http://www.singlife.com/pdpa">www.singlife.com/pdpa</a> . 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.	
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:.....