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Singlife

GROUP LIFE & HEALTH CLAIMS
TOTAL AND PERMANENT DISABILITY CLAIM FORM
CLAIMANT'S STATEMENT

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

The insurer does not admit liability by the mere issue of this form.

Name of Company: _____ Policy No: _____

SECTION I (TO BE COMPLETED BY CLAIMANT)

1. PERSONAL PARTICULARS			
Name of Claimant	NRIC/Passport	Date of Birth (DD/MM/YY)	Gender ☐ F ☐ M
Email Address	Mobile No	Marital Status	
Present Address:			
Date of Employment (DD/MM/YY):		Commencement Date of Insurance (DD/MM/YY):	

2. DETAILS OF OCCUPATION		
Occupation	Before Disability	After Disability
Average Monthly Income (Please furnish a copy of last payroll)		
List exact duties performed at work *		

*** If you are not working, please provide a list of daily activities before and after the disability.** Singapore Life Ltd. **reserves the right to request for documentary evidence.**

3. DETAILS OF DISABILITY		
a) Is this disability suffered due to:	☐ Illness (Date of Symptoms Started)	☐ Accident (Date / Time of Accident)
b) Describe in details all symptoms and/or nature of injuries / disability suffered		
c) Date of last work:	d) Are you currently confined to: ☐ Bed ☐ Home ☐ Neither	
e) Date you return to work _____ OR date you expected to return to work _____		

4. DETAILS OF PHYSICIAN(S) CONSULTED OR HOSPITAL(S) ADMITTED FOR THIS DISABILITY		
Name (s)	Address (es)	Admission Date (s)

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5. DETAILS OF YOUR REGULAR PHYSICIAN OR ANY OTHER PHYSICIAN(S) CONSULTED FOR ANY OTHER DISORDERS IN THE PAST THREE YEARS		
Names(s)	**Address(es)**	**Admission Date(s)**

6. OTHER CLAIMS		
Are you claiming from any other insurance company or other sources in respect of this disability? If Yes, please provide the following information:		
Name of Company	**Amount Claimed**	**Policy No (if applicable)**

AUTHORISATION & CONSENT

This part must be signed by the patient's parent / legal guardian if the patient is below 21 years old.

I/We hereby authorise any hospital, physician, person or organization to disclose when requested to do so by Singapore Life Ltd. ("Singlife")**, any and all information with respect to** any illness, or injury, medical history, consultations, prescriptions or treatment and copies of all hospital or medical records. A photostat copy 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 Policy 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 Claimant:_____ **Date:**_____

(TO BE COMPLETED BY ASSURED COMPANY)

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:**

_____ **Signature of Employer**

_____ **Company's Name / Stamp**

_____ **Date**

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SECTION II (TO BE COMPLETED BY ATTENDING PHYSICIAN AT INSURED'S EXPENSE)

Name of Patient:	NRIC/Passport No:

PART A – PATIENT'S CONDITION

1. CONSULTATION FOR PRESENT ILLNESS / INJUR(IES)

a) Are you the patient's usual physician? ☐ Yes ☐ No If Yes, since what date?

_____

b) When did the patient first consult you for this illness or injur(ies)?

_____

c) Please provide details on:

i) Symptoms presented _____

ii) Duration of these symptoms _____

iii) Diagnosis _____

iv) Date of Diagnosis _____

v) Was the diagnosis made known to the patient? ☐ Yes ☐ No If Yes, when? If No, why?

_____

d) If consultation was for injur(ies), please describe injuries:

_____

2. Please describe treatment, including any operations performed.

_____

_____

_____

_____

3. If the patient was referred from a clinic or hospital, please state:

a) Name of Physician: _____

b) Name of Clinic/Hospital: _____

c) Date Referred: _____

4. Has patient been admitted to hospital before for the same illness/injur(ies)? ☐ Yes ☐ No If Yes, please state

a) Date admitted _____ b) Date discharged _____

c) Name of hospital _____ d) Admission No _____

5. Has the patient suffered or is suffering from any other disease or ailment? If so, please give details

_____

_____

_____

a) Date patient first suffered from the disease or ailment _____

b) Name and address of Physician consulted _____

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6. Based on your assessment on the patient, please indicate below what best to describe the patient's disability status:

☐ Good recovery – can lead a full and independent life with or without minimal neurological deficit.

☐ Moderately disabled – has neurological or intellectual impairment but independent.

☐ Severely disabled – conscious but totally dependent on others to get through daily activities.

☐ Vegetative survival.

7. Is the patient able to return to his/her usual occupation?

☐ If Yes, please elaborate when can he/she return to work and what is the limitation?

_____

☐ If No, please elaborate to what extend does his/her disability prevent him/her from performing all the normal duties of his/her usual occupation? When can he/she return to work, what is his/her limitation?

_____

☐ What other type of occupation can the patient perform?

_____

8. In your opinion, would the patient's condition lead to death within the next 12 months from the date of diagnosis?

_____

9. Please provide us with any other additional information that will enable the company to assess this claim.

_____

_____
Signature of Physician / Surgeon

_____
Date

_____
Name / Designation

_____
Name and Address of Clinic / Hospital & Stamp

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PART B – ACTIVITIES OF DAILY LIVING

Please comment on whether the patient is able to perform the following activities of daily living:

Activity	Score
Feeding 0 = unable 5 = need help cutting, spreading butter, ect., or require soft diet 10 = independent	☐ 0 ☐ 5 ☐ 10
Bathing 0 = dependent 5 = independent (or in shower)	☐ 0 ☐ 5
Grooming 0 = needs to help with personal care 5 = independent [(face / hair / teeth / shaving (implements provided)]	☐ 0 ☐ 5
Dressing 0 = dependent 5 = need help but can do about half unaided 10 = independent (including buttons, zip, laces, ect)	☐ 0 ☐ 5 ☐ 10
Bowels 0 = incontinent (or needs to be given enemas) 5 = occasional accident 10 = continent	☐ 0 ☐ 5 ☐ 10
Bladder 0 = incontinent or catheterised and unable to manage alone 5 = occasional accident 10 = continent	☐ 0 ☐ 5 ☐ 10
Toilet Use 0 = dependent 5 = needs some help, but can do something alone 10 = independent (on and off, dressing, wiping)	☐ 0 ☐ 5 ☐ 10
Transfer (bed to chair and back) 0 = unable, no sitting balance 5 = major help (one or two people, physical), can sit 10 = minor help (verbal or physical) 15 = independent	☐ 0 ☐ 5 ☐ 10 ☐ 15
Mobility (on level surfaces) 0 = immobile or < 50 yards 5 = wheelchair independent, including corners > 50 yards 10 = walks with help of one person (verbal or physical) > 50 yards 15 = independent (but may use any aid; for example, stick) > 50 yards	☐ 0 ☐ 5 ☐ 10 ☐ 15
Stairs 0 = unable 5 = needs help (verbal, physical, carrying aid) 10 = independent	☐ 0 ☐ 5 ☐ 10

_____
Signature of Physician / Surgeon

_____
Date

_____
Name / Designation

_____
Name and Address of Clinic / Hospital & Stamp