



AVIVA LTD
 4 Shenton Way #01-01, SGX Centre 2,
 Singapore 068807
 Telephone: 6827 7988 Fax: 6827 7705

GROUP LIFE & HEALTH CLAIMS

TOTAL AND PERMANENT DISABILITY CLAIM FORM – CLAIMANT’S STATEMENT

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

SECTION I (TO BE COMPLETED BY CLAIMANT)

POLICY NO: _____

1. PERSONAL PARTICULARS		
(a) Name of Claimant: _____	(b) NRIC No.: _____	
(c) Date of Birth: _____	(d) Sex: _____	(e) Marital Status: _____
(f) Home Address: _____	Tel (O): _____	
	Tel (H): _____	
(g) Date of Employment: _____ (h) Commencement Date of Insurance: _____		
2. DETAILS OF OCCUPATION		
	Before disability	After disability
(a) Occupation	_____	_____
(b) Name of employer	_____	_____
(c) Average monthly income (Please furnish copy of last payroll)	_____	_____
(d) List exact duties performed at work	_____	_____
(See Note (i))	_____	_____
	_____	_____
	_____	_____
NOTE: i) If you are not working, please provide a list of daily activities before and after the disability. ii) The company reserves the right to request for documentary evidence.		
3. DETAILS OF DISABILITY		
(a) Is the disability suffered due to:		
<input type="checkbox"/>	illness (date symptoms started _____)	
<input type="checkbox"/>	accident (date/time of accident _____)	
(b) Describe in detail all symptoms and/or nature of injuries/disability suffered		

(c) Date you last work _____

(d) Are you currently confined to:
 bed house neither

(e) Date you returned to work _____ OR date you expect to return to work _____

4. DETAILS OF PHYSICIAN (S) CONSULTED OR HOSPITAL (S) ADMITTED FOR THIS DISABILITY

Name (s)	Address(es)	Admission dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. DETAILS OF YOUR REGULAR PHYSICIAN OR ANY OTHER PHYSICIAN(S) CONSULTED FOR ANY OTHER DISORDERS IN THE PAST THREE YEARS

Name (s)	Address(es)	Reason for Consultation
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. OTHER CLAIMS
 Are you claiming from any other insurance company or other sources in respect of this disability?
 If yes, please provide following information:

Name of company	Amount claimed	Policy No.(if applicable)
_____	_____	_____
_____	_____	_____

MEDICAL INFORMATION AUTHORISATION

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

I hereby authorised any hospital, physician, or other person who has attended me or examined me, to disclose when requested to do so by AVIVA LIMITED, 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 certify that the above statement and answers are true and complete to the best of my knowledge and belief.

Name of Claimant : Signature of Claimant:

Address :

Contact No : Date :

(NOTE: THIS SECTION IS FOR GROUP POLICYHOLDERS ONLY)

1) Name of 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: _____

 Signature of Employer Company's Name/Stamp Date



AVIVA LTD

4 Shenton Way #01-01, SGX Centre 2,

Singapore 068807

Telephone: 6827 7988 Fax: 6827 7705

GROUP LIFE & HEALTH CLAIMS

TOTAL AND PERMANENT DISABILITY CLAIM FORM – PHYSICIAN’S STATEMENT

SECTION II (to be completed by attending physician at insured’s expense)

Name of patient: _____	NRIC No.: _____
PART A – PATIENT’S CONDITION	
1. CONSULTATION FOR PRESENT ILLNESS/INJUR(IES)	
(a) Are you the patient’s usual physician? If yes, since what date?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

(c) If consultation was for illness, please provide the following information:	
i) symptoms presented	_____
ii) duration of these symptoms	_____
iii) diagnosis	_____
iv) was the diagnosis made known to the patient? If yes, when? If no, why?	<input type="checkbox"/> Yes <input type="checkbox"/> No

(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.

(b) Date he first suffered from the disease or ailment _____

(c) Name and address of physician consulted _____

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 is 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 usual occupation?

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

- If No, please elaborate:

To what extent does his disability prevent him from performing all the normal duties of his usual occupation? When can he return to work, what is the 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.

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 = needs help cutting, spreading butter, etc., or requires 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 = needs help but can do about half unaided 10 = independent (including buttons, zips, laces, etc.)	0 5 10
Bowels 0 = incontinent (or needs to be given enemas) 5 = occasional accident 10 = continent	0 5 10
Bladder 0 = incontinent, or catheterized 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
Transfers (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

<p>Mobility (on level surfaces)</p> <p>0 = immobile or < 50 yards</p> <p>5 = wheelchair independent, including corners, > 50 yards</p> <p>10 = walks with help of one person (verbal or physical) > 50 yards</p> <p>15 = independent (but may use any aid; for example, stick) > 50 yards</p>	<p>0 5 10 15</p>
--	------------------

<p>Stairs</p> <p>0 = unable</p> <p>5 = needs help (verbal, physical, carrying aid)</p> <p>10 = independent</p>	<p>0 5 10</p>
---	---------------

<p>Name of Physician : _____</p> <p>Signature of Physician : _____</p> <p>Date : _____</p> <p>Clinic's Address & Stamp: _____</p> <p>_____</p> <p>_____</p>
