



TOTAL AND PERMANENT DISABILITY / LONG TERM CARE CLAIM FORM

AIA SINGAPORE PRIVATE LIMITED (Reg. No. 201106386R)

FSC/IR: _____
Agency: _____
Contact No.: _____

PART 1 (To be completed by Insured)

Policy No. : _____

Name:	NRIC/FIN/Passport No.	
Address:	Age:	Sex:
Is the disability suffered a result of: a) accident <input type="checkbox"/> b) illness <input type="checkbox"/> Date of accident/symptoms of illness first started: (DD/MM/YY) _____	Occupation (at time of disability): Employer (at time of disability):	
What date did you stop all work: (DD/MM/YY) _____ Are you currently confined to bed or house: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please specify:	What date did you return to work: (DD/MM/YY) _____ If not, give expected date of return: (DD/MM/YY) _____	

Occupation Details	Occupation	Average Monthly Income	Scope of duties performed in job
Before Disability			
After Disability			

Have you ever been or are you at present insured for disability benefits with any other company? Yes No
(If yes, please provide the following information)

Name of Companies	Amount of Insurance	Policy Number
1)		
2)		

Details of physician(s) consulted or hospital(s) confined for disability:

Name	Address	Date of Attendance (From) (To)

Authorization & Declaration

I declare that the answers given above are true to the best of my knowledge and belief.

I/We hereby irrevocably authorize any hospital, doctor, or other person/organization/institution to furnish AIA Singapore Private Limited ("the Company") or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records or reports, and other personal information of the insured or policyowner. This authorization shall bind my/our successors and assigns and remain valid notwithstanding my/our death or incapacity in so far as legally possible. I/We agree that a photocopy of this authorization shall be considered as effective and valid as the original.

I/We hereby authorise, agree and consent to the Company to use and/or disclose any information collected and/or held (whether contained in this application or otherwise obtained) to enable the Company, its associated individuals/organisations and/or independent third parties, within or outside Singapore, with regard to any matters pertaining to the Application/Policy and/or any other policies that I/we currently may have with the Company, including but not limited to, processing of this Application, and/or providing subsequent services to me/us and/or providing advice and/or information concerning products and/or services which the Company believes may be of interest to me/us and/or communicating with me/us for any purpose. I/We hereby specifically waive any right to bring a claim of any nature against the Company, its associated individuals/organisations and/or independent third parties, within or outside Singapore, in respect of any above-mentioned disclosure and/or any disclosure in the nature described above. This authorisation shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not my/our Application is accepted by the Company. A photocopy of this authorisation shall be effective and valid as the original.

Date: _____ Signature/Thumbprint of Insured _____

Note: No fees, commissions or charges of whatever nature are payable to agents or employees of the company in respect of this claim.



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ATTENDING PHYSICIAN'S STATEMENT

PART II (To be completed by doctor at Insured's expense)

Name of Insured:	NRIC/FIN/Passport No.	Occupation declared to you at first consultation:
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History and Circumstances Leading to Disability

a. Date of disability first started (DD/MM/YY)

b. Date when the insured first consulted you for this illness (DD/MM/YY):

c. The symptoms which the insured first related to you on the first consultation:

d. According to the insured, the duration he/she had been experiencing these symptoms:

e. Has the insured previously suffered from the illness or any related condition before? If yes, please give dates of consultations and the resulting diagnosis.

Clinical and Physical Findings on First Consultation

a. The symptoms or physical impairments of the insured observed by you at the first consultation.

b. The diagnosis of the insured:

c. If the insured is suffering from Advanced Dementia (including Alzheimer's Disease), please complete the following questions:

i. Is there any evidence of deterioration or loss of intellectual capacity or abnormal behaviour resulting in significant reduction in mental and social functioning requiring the continuous supervision of insured? Yes No

If yes, please specify:

Remarks: _____

ii. Did the deterioration or loss of intellectual capacity or abnormal behaviour arise from neurosis, psychiatric illness and any drug or alcohol related organic disorder? Yes No

If yes, please specify:

Remarks: _____

d. The date when the insured was first made aware of the illness (DD/MM/YY):

Current Health of Insured

a. The date when the insured last consulted you (DD/MM/YY):

b. Please state the progress of recovery of the insured:

Recovered Improving Static Retrogressed

c. Current state of mobility:

Ambulating without aid Confined to home Confined to bed

Confined to hospital Confined to wheelchair

Please give name of hospital and the period of hospital confinement, if any.

d. Is the insured able to perform without assistance the following (please tick your answer):

i. Ability to wash and bathe oneself. Yes No

ii. Ability to dress/undress oneself. Yes No

iii. Ability to attend to one's own toilet needs. Yes No

iv. Ability to feed oneself. Yes No

v. Ability to move independently in and out of bed or a chair. Yes No

vi. Ability to move indoors from room to room on level surface. Yes No

e. Please describe the current mental impairment of the insured, if any.

Prognosis and Rehabilitation

a. How do you assess the extent of insured's disability?

Totally disabled Partially disabled Too early to determine

Please give date of next review (DD/MM/YY): _____

b. If insured is not totally disabled, what other jobs is he/she capable of performing?

c. If insured is presently totally disabled, how soon is the insured expected to recover from his/her disability?

1-3 mths 3-6 mths

6-12 mths >12 mths

Most unlikely to recover

Remarks: _____

d. Please state any further treatment / rehabilitation plan.



Additional Information

If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.

Please provide name and address of doctor who referred him/her to you

To be completed by Attending Physician / Specialist

Name Of Doctor: _____

Qualification: _____

Signature: _____

Address/Official Stamp:

Date: _____