DISABILITY CLAIM PROCEDURE

Documents Required

1. Disability Claim Form: Part I.
2. Disability Claim Form: Part II Medical Specialist Report (report fee to be borne by Claimant).
3. Copy of Medical Document such as resting ECGs, exercise stress test, troponin results, enzymes assays, isotope studies imaging coronary angiography, blood tests, ultrasound, biopsy, histopathology report, CT scans, other imaging studies, laboratory evidence and any relevant hospital reports that are available.
4. Employment and/or income documents, eg. confirmation from employer on absence from work, termination letter, pay slips, IR8A Form, CPF statements, Commission Statement, etc. (Please refer to Important Notes (a) below)
5. Copies of all medical leave certificates
6. Copy of the bank book or bank statement stating account holder name and number must be provided if the selected payment method is Telegraphic Fund Transfer.

Important Notes

a. For temporary loss of income due to disability claim (eg. Premier Disability Plan), you need to produce the Insured's income documents and any additional evidence at your sole cost and expense to evidence any loss in income. You also need to disclose any other sources of income that the Insured is or may be receiving for the purpose of replacing loss of income due to disability.

b. Part II Medical Specialist Report must be completed by your Medical Specialist and the Medical Report fee charged will be borne by you.

c. All documents submitted must be in English. Any document that is not in English must be accompanied by an English translated copy of the document made by a certified translator/interpreter.

d. All questions in Part I of the Claim Form must be fully answered. The Company reserves the right to require or obtain further information, if deemed necessary.

e. The Part I of the Claim Form must be signed using the same signature as in AIA Singapore's records.

Submission Of Documents

All claims required documents can be submitted to AIA Singapore. You may submit the claim application together with all of the requirement to AIA Singapore in any of the following way:

- By postal mail to AIA Singapore Claims Department at
  AIA Singapore Claims Department
  3 Tampines Grande #09-01
  Singapore 528799
  Attention: Claims Department (Individual Life & Health)
- Contact your servicing insurance adviser to assist you.

Submit your claim application in person at AIA Singapore Customer Service Centres

- Finlayson Green at **1 Finlayson Green, Singapore 049246**
  Operating Hours: Mondays to Fridays 8.45am to 5.30pm excluding Public Holidays
- AIA Tampines at **3 Tampines Grande, Singapore 528799**
  Operating Hours: Mondays to Fridays 8.45am to 5.30pm excluding Public Holidays

AIA SINGAPORE
DISABILITY CLAIM FORM

PART 1 (To be completed by Insured or Policy Owner if Insured is a minor)

(A) POLICY DETAILS			
Policy Number(s):			
(B) PARTICULARS OF INSURED			
Name of Insured:	NRIC/Passport No./FIN No.:	Age:	Contact No.:
Mailing Address: Postal Code ( )			
Employment Status (at time of disability): (a) Employed / Self-Employed / Unemployed* (b) Permanent Basis / Contract Basis / Temporary Basis / Not Applicable* (c) Full Time / Part Time / Not Applicable* *Please delete accordingly.	Company Name and Business Address (at time of disability): Nature of Business / Trade:		

(C) CLAIM BENEFIT

Please indicate the benefit(s) the Insured is claiming for:

□ Total and Permanent Disability Benefit
□ Long Term Care Benefit
□ Loss of Income Benefit (eg. Premier Disability Cover)
□ Others (please specify) _____

(D) DETAILS OF OCCUPATION / ACTIVITIES OF DAILY LIVINGS (ADLs)

1. If Insured is **self-employed/employed**, please answer question 1(a) to 1(h)

Details of Occupation:	Before Disability	After Disability
(a) Occupation		
(b) Job Title		
(c) Name of Employer / Company		
(d) Average Monthly Income		

(e) What are the major duties (*including managerial/supervisory role*) of Insured's occupation?

Please indicate the percentage (%) of time spent performing these functions.

Duties	% Time	Duties	% Time

(f) If Insured is issued with hospitalisation leave and/or medical leave, please provide the duration.

Types of Leave	From (dd/mm/yy)	To (dd/mm/yy)
Hospitalisation Leave		
Medical Leave		

L1TPDFM

(g) Please provide the date that the Insured stop all works.	_____/_____/_____ (dd/mm/yy)
(h) Please provide the details of the Insured during the employment period.	Has the Insured returned to work to resume full or light duties during the disability period? □ Yes, full duties □ Yes, light duties □ No □ Not Applicable (for Unemployed) If "Yes", please provide the date the Insured return to work : _____/_____/_____ (dd/mm/yy) If "No", please provide the expected date of return (if any) : _____/_____/_____ (dd/mm/yy)
2. If Insured is **unemployed,** (eg. housewife, etc.) please answer below question:	
Please indicate the Activities of Daily Living (ADLs) that the Insured is able to perform independently (ie. without assistance) after Disability.	□ **Transferring:** The ability to move from a bed to an upright chair or wheelchair and vice versa □ **Mobility:** The ability to move indoors from room to room on level surfaces □ **Toileting:** The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene □ **Dressing:** The ability to put on, take off, secure and unfasten all garments and as appropriate, any braces, artificial limbs or other surgical appliances □ **Washing:** The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by any other means □ **Feeding:** The ability to feed oneself once food has been prepared and made available
(E) DETAILS OF DISABILITY	
1. Is the Insured currently confined to:	□ Bed □ House □ Hospital □ Wheelchair □ Neither
2. Is the disability suffered a result of:	□ Illness (please answer question 3) □ Accident (please answer question 4)
3. If the condition / disability suffered are due to illness, please provide the details.	3a. Describe fully the symptoms, including duration.
	3b. Please state the date of onset of the symptoms : _____/_____/_____ (dd/mm/yy)
	3c. Date first consulted a doctor for the symptoms/illness : _____/_____/_____ (dd/mm/yy)
	3d. Have Insured suffered from this or any related condition before? □ Yes □ No If "Yes", please provide details. _____

4. If the condition / disability suffered are due to accident, please provide the details.

4a. Date of Accident: _____/_____/_____ (dd/mm/yy)

Time of accident: _____am/pm

4b. Type of accident (please indicate the relevant):

□ Road Traffic Accident □ Hit by heavy object/person □ Pricked by sharp object
□ Industrial Accident □ Foreign body hitting eye □ Burns and scalds
□ Slipped and Fell □ Cut by substance/device
□ Others (please specify): _____

4c. Please describe the details of the accident.

4d. Please describe the extent of the injury(ies).

4e. If there is a police investigation carried out, please provide the below details together with a copy of the police report □ Yes □ No

Name(s) of Investigation Officer Charge	Police Station (Branch/Address)

5. Details of the surgery (if any).

6. Please provide the details of the doctor(s) whom the Insured consulted for the symptoms/illness/injury.

Name and Address of the Doctor	Illness/Injury	Date of First consultation (dd/mm/yy)	Date of Latest consultation (dd/mm/yy)	Date of Next consultation (dd/mm/yy)

7. Please provide the details of the hospitalisation in connection with this illness/injury.

Name and Address of the Hospital	Name of the Attending Doctor(s)	Period of Hospitalisation (dd/mm/yy)

8. Please provide the details of the Insured's regular doctor.

Name of the Doctor(s)	Address

(F) TO BE COMPLETED FOR LOSS OF INCOME CLAIM (eg. Premier Disability Cover (PDC) Plan)

1. For **self-employed** Insured, please complete the following:

(a) Number of Partners (if any): _____

(b) Number of Employees (if any): _____

(c) Have Insured's business operations ceased completely during the period of disability? □ Yes □ No
If "No", please provide details.

_____

_____

(d) Has Insured's business generated any income since the commencement of disability? □ Yes □ No
If "Yes", please provide details.

_____

2. For **employed** Insured, has an alternative job been made available to Insured by the employer? □ Yes □ No
If "Yes", what position was provided for the Insured, and how did this differ from the usual role?

_____

3. For **self-employed/employed** Insured, please answer 3a-3b.

(a) What qualifications do Insured hold either academic or work related:

S/N	Qualification	Date Acquired

(b) Please give details of the Insured's previous employment, either with the current or other employers:

S/N	Dates (To and From)	Title	Brief Description

(G) OTHER INSURANCE

1. Is the Insured also insured by any other company(ies) for similar risks/benefits? □ Yes □ No If "Yes", please provide details as below.

Insurance Company	Date of Issue (dd/mm/yy)	Sum Insured (S$)	Has the claim been approved?

(H) PAYMENT METHOD FOR CLAIM SETTLEMENT

☐ Cheque to be mailed directly to the Policy Owner's dispatch address in our record

☐ Cheque to be collected by Policy Owner at AIA Customer Service Centre at

☐ Finlayson Green

☐ AIA Tampines

☐ Cheque to be collected by AIA Singapore servicing insurance adviser for delivery to Policy Owner

Name of insurance adviser: _____

Name of agency: _____

Contact number of insurance adviser: _____

☐ Telegraphic Fund Transfer (For Policy Owner residing overseas)
Note: A copy of the bank book or bank statement stating account holder name and number is required.
Remittance to overseas foreign accounts is subjected to AIA Singapore's approval.

Bank Account Number: _____

Name of Bank: _____

Address of Bank: _____

Country of Bank: _____

Swift Code: _____

Policy Owner's Contact Number: _____

Policy Owner's Address: _____

Patient's Name:
Patient's NRIC/Passport No./FIN No.:
Policy Number:

Name of Insured: NRIC/FIN/Passport No.:

(I) AUTHORISATION & DECLARATION

1. I/We, acknowledge and accept that the furnishing of this form, or of any other forms supplemental thereto, by AIA Singapore Private Limited ("AIA Singapore") is neither an admission that there was any insurance in force on the life in question, nor an admission of liability nor a waiver of any of its rights or defenses.

2. I/We:
(a) hereby declare that I/we are duly authorized to make this claim and all statements and responses whether on this form or otherwise together with any required questionnaire, amendments, materials and supporting documents submitted in connection with the claim and the Policy ("Information");
(b) declare that all Information is complete, true and correct and that no information or materials have been withheld and that AIA Singapore will rely and act on the Information accordingly. Otherwise, AIA Singapore shall be at liberty to deny liability or recover amounts paid, whether wholly or partially;
(c) acknowledge and accept that AIA Singapore shall be at liberty to deny liability or recover amounts paid, whether wholly or partially, if any of the Information is incomplete, untrue or incorrect in any respect or if the Policy does not provide cover on which such claim is made; and
(d) acknowledge and accept that AIA Singapore expressly reserves its rights to require or obtain further information as it deems necessary.

3. I/We hereby authorise, agree and consent to:
(a) persons and organizations, whether within or outside Singapore, including but not limited to medical sources, hospitals, doctors, other healthcare professionals, laboratories, regulator, dispute resolution centres and insurers, their associated persons/organizations, my/our or the insured person's employers or financial service providers, or their third party service providers or representatives (collectively "**Third Parties**") disclosing and releasing to AIA Singapore, its associated persons/organizations, its and their third party service providers and its and their representatives, whether within or outside Singapore (collectively "**AIA Persons**"), any information concerning the policy owner and the insured person(s) at any time, including all personal data and information, medical information, medical history, consultation history and notes, prescriptions, treatments, descriptions of medical services rendered, and any employment and financial information, including the taking of copies of such records (collectively "**Personal Data**"), relevant for the Purpose (defined below);
(b) the AIA Persons sharing the scope of sub-clause
(c) the AIA Persons, including their approved medical examiners or laboratories, performing any necessary medical assessments and examinations and tests to determine, assess and evaluate the health of the insured person(s);
(d) the AIA Persons collecting, using, disclosing, storing, retaining and/or processing (collectively, "**Using"/"Use**") the Personal Data for the Purpose; and
(e) waive any right (on my own behalf and on behalf of the insured person(s) where applicable, in respect of which I/we represent and warrant that the insured person(s) have granted me/us authority to so waive) to bring a claim of any nature against any of the AIA Persons in respect of any above-mentioned Use and/or any Use of any Personal Data for the Purpose.

Where I/we are not the insured person, I/we represent and warrant that I/we have obtained the consent of the insured person(s), except to the extent such consent is not required under relevant laws: (i) to collect their Personal Data; (ii) to disclose their Personal Data to the AIA Persons; and (iii) for the AIA Persons and Third Parties to Use any of their Personal Data in the manner and for the purposes described in this Clause. I/We hereby agree to indemnify AIA Persons for all losses and damages that AIA Persons may suffer in the event that I/we are in breach of any representation and warranty provided by me/us herein. In this Clause, "**Purpose**" means any of the purposes described in the AIA Personal Data Policy, including but not limited to processing of this form, to provide subsequent advice or services to me/us or the insured person in relation to any existing or future policy/policies/programmes that I/we may hold/participate with AIA Singapore.

4 This authorisation and declaration shall bind my/our successors and assignees, and remains valid, notwithstanding death or incapacity. A photocopy of this authorisation shall be effective and valid as the original.

Signature of Insured/Policy Owner *(if Insured is a minor)*

Date

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

L2CSENT

Patient's Name:
Patient's NRIC/Passport No./FIN No.:
Policy Number:

PART II - Medical Specialist Report (To be completed by the Medical Specialist at patient's expense)

(A) PATIENT'S PARTICULARS (FROM HOSPITAL/CLINIC'S RECORD)	
Patient Name:	NRIC/Passport No./FIN No.:

(B) PATIENT'S MEDICAL RECORDS			
1. Are you the patient's regular medical doctor?	□ Yes □ No If "No" please provide name and address of the patient's regular doctor.		
	Name & Address of Regular Doctor		
2. Please state the date of first and last consultation(s) with the date of next review/follow-up (if any).	Date of First Consultation (dd/mm/yy)	Date of Latest Consultation (dd/mm/yy)	Date of Next Review/Follow-up (dd/mm/yy)
3. If patient is hospitalised, please provide the details of the hospitalisation.	Name and Address of the Hospital	Name of the Attending Doctor(s)	Period of Hospitalisation (dd/mm/yy)
4. How often does the patient required to turn-up for follow-up consultations?	□ Monthly □ Quarterly □ Semi-Annually □ Annually		

(C) DETAILS OF DISABILITY			
1. Please provide the date of disability **first** started.	Date :_____/_____/_____(dd/mm/yy)		
2. What were the **physical/mental** signs and symptoms presented by the patient during the **latest** visit?			
3. What is the patient's current main **physical/mental** impairment based on the **latest** visit?			
4. Please provide the details of the patient's occupation before disability.	Occupation Before Disability	Main Duties	Any Other Duties
5. Based on the **latest** visit, is the patient able to perform all the normal duties of his usual occupation as stated in Question 4 above?	□ Yes □ No If No, please answer 5a and 5b:		
	5a. Please describe how the **physical/mental** impairment(s) stated in Question 3 prevented the patient from performing the listed duties in Question 4.		
	5b. Please provide the date that the patient is expected to return to his/her usual occupation in Question 4. Date :_____/_____/_____(dd/mm/yy)		

L4MEDRT

Patient's Name:
Patient's NRIC/Passport No./FIN No.:
Policy Number:

6.	Please state the current state of mobility based on the **latest** visit.	□ Confined to home □ Confined to bed □ Confined to hospital □ Confined to wheelchair □ Ambulating without aid □ Ambulating with aid (Please specify: _____)		
7.	Please state the progress of recovery of the patient based on the **latest** visit.	□ Recovered □ Improving □ Static □ Retrogressed		
8.	Please **circle** as applicable in relation to the patient's Activities of Daily Living (ADLs) ability based on the **latest** visit.			Please provide details.
(a)	**Washing/Bathing** – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.	• Able to perform independently and without any assistance. • Able to perform with the aid of special equipment. • Always require the physical assistance of another person throughout the entire activity.	Yes / No Yes / No Yes / No	
(b)	**Dressing** – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.	• Able to perform independently and without any assistance. • Able to perform with the aid of special equipment. • Always require the physical assistance of another person throughout the entire activity.	Yes / No Yes / No Yes / No	
(c)	**Transferring** – the ability to move from a bed to an upright chair or wheelchair and vice versa.	• Able to perform independently and without any assistance. • Able to perform with the aid of special equipment. • Always require the physical assistance of another person throughout the entire activity.	Yes / No Yes / No Yes / No	
(d)	**Mobility** – the ability to move indoors from room to room on level surfaces.	• Able to perform independently and without any assistance. • Able to perform with the aid of special equipment. • Always require the physical assistance of another person throughout the entire activity.	Yes / No Yes / No Yes / No	
(e)	**Toileting** – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	• Able to perform independently and without any assistance. • Able to perform with the aid of special equipment. • Always require the physical assistance of another person throughout the entire activity.	Yes / No Yes / No Yes / No	

(f) **Feeding** – the ability to feed oneself once food has been prepared and made available.	• Able to perform independently and without any assistance. • Able to perform with the aid of special equipment. • Always require the physical assistance of another person throughout the entire activity.	Yes / No Yes / No Yes / No	
9. How do you assess the extent of patient's disability based on the **latest** visit?	□ Totally Disabled □ Partially Disabled □ Too early to determine If the incapability of patient cannot be determined at this moment, what is the appropriate time period for the Company to re-assess this claim? _____/_____/_____(dd/mm/yy)		
10. Is the disability suffered a result of:	□ Illness (please answer Section D: Details of Illness) □ Accident (please answer Section E: Details of Accident)		

(D) DETAILS OF ILLNESS

1. When did the patient **first** consult you for the condition?	Date :_____/_____/_____(dd/mm/yy)	
2. What were the sign(s) and symptom(s) presented during the **first** consultation?		
3. When the sign(s) and symptom(s) **first** started (dd/mm/yy)?		
4. Please state the exact diagnosis and the date of diagnosis of the condition.	Diagnosis	Date of Diagnosis (dd/mm/yy)

(E) DETAILS OF ACCIDENT

1. Date and time of accident.	Date :_____/_____/_____(dd/mm/yy) Time:_____a.m./p.m.
2. Please describe how the accident occurred.	
3. Please describe the injuries sustained by the patient, including extent of injury and state the anatomical site involved.	
4. Country and place where the accident occurred.	
5. Was the accident reported to the police?	□ Yes □ No If "Yes", enclose copy of the report (if available)

6. Was the patient under the influence of alcohol/drugs at the time of accident?	□ Yes □ No If "Yes", please state the blood alcohol content/drug type and quantity consumed.
(F) OTHER DETAILS (Please complete this part in full for all claims)	
1. Is the patient's condition self-inflicted or as a result of suicide?	□ Yes □ No If "Yes", please provide details.
2. Is patient's condition AIDS related or due to sexually transmitted disease?	□ Yes □ No If "Yes", please provide details:
3. Is the patient's condition a mental or nervous disorder?	□ Yes □ No If "Yes", please provide details.
4. Is the patient suffering from Advanced Dementia (including Alzheimer's Disease)?	□ Yes □ No If "Yes", please provide the following information:
	4a. If there is evidence of deterioration or loss of intellectual capacity, please describe the findings.
	4b. If there is abnormal behavior resulting in significant reduction in mental and social functioning and requiring continuous supervision of the patient, please describe the findings.
	4c. Please indicate if the deterioration or loss of intellectual capacity or abnormal behavior arise from any of the following: □ Neurosis □ Any drug or alcohol related organic disorders □ Psychiatric illness □ Other non-organic diseases If you have indicated any of the above condition, please elaborate.
5. Does the illness/injury result in the <u>permanent</u> total loss of use of the area involved?	□ Yes □ No If "Yes", provide details and extent of such involvement.
6. Is the patient physically and/or mentally incapacitated from ever continuing in <u>any</u> employment?	□ Yes □ No If "Yes", please answer 6a. If "No", please answer 6b.
	6a. Please describe how the mental and physical impairment(s) prevent the patient from ever continuing in <u>any</u> employment.
	6b. If the patient is <u>not</u> physically and/or mentally incapacitated from ever continuing in <u>any</u> employment, what are the jobs he/she is capable of performing?

Patient's Name:
Patient's NRIC/Passport No./FIN No.:
Policy Number:

7. Is the patient mentally incapacitated in accordance to the Mentally Capacity Act (Chapter 177A of Singapore)?	□ Yes □ No
8. Is the patient mentally capable of receiving or handling money, including monies received from claims settlement?	□ Yes □ No If "Yes, please elaborate.
9. To the best of your knowledge, is the patient's next-of-kin in the midst applying Court Order to help manage patient's finances?	□ Yes □ No
10. If answer to question (9) is "Yes", please let us know who will be applying and the progress of the application to the best of your knowledge. _____	
11. If patient is presently <u>totally / partially</u> disabled, how soon is patient expected to recover from his/her disability?	□ 1-3 months □ 3-6 months □ 6-12 months □ Most unlikely to recover Please provide details on the basis of your evaluation.
12. Is the disability permanent and beyond any hope of recovery?	□ Yes □ No Please provide details on the basis of your evaluation.
13. What is the prognosis of patient's condition?	□ Poor □ Guarded □ Fair □ Good □ Excellent Please provide details on the basis of your evaluation:
14. In your opinion, is the condition highly likely to lead to death within the next 12 months?	□ Yes □ No If "Yes", please provide details on the basis of your evaluation.

15. Please provide treatment(s) administered and the dates.	Treatment Administered	Date(s) of Treatment

16. Is the patient's present illness or condition caused by any other underlying disorders?	□ Yes □ No If "Yes", please provide details:	
	Condition(s)	Date(s) of Consultation

17. Have you treated the patient for any other condition(s) other than this current condition?	□ Yes □ No If "Yes", please provide details:			
	Name & Address of Doctor	Consultation Period	Condition(s)	Treatments

18. Will you agree and authorise us to release this medical information if such disclosure is required by Financial Industry Disputes Resolution Centre Ltd (FIDReC) of Singapore or any proper Government Authority?	□ Yes □ No

IMPORTANT: To enable us to proceed with the claim, kindly enclose copies of all reports including X-rays, CT scans, ultrasound or other studies, ECG, surgical reports, laboratory evidence, physiotherapist and/or follow-up injury assessment report and/or any relevant hospital reports that are available.

(G) MEDICAL SPECIALIST'S NAME & SIGNATURE

Name of Medical Specialist : _____

MCR No : _____

Signature : _____

Date : _____

Address/Official Stamp: