

Dear Claimant

We are sorry to learn of your disability.

In order for us to process the claim, we require the following:

1. **Disability Claim Form**
2. Attending Physician's Statement
3. **Original** Policy Document
4. Copy of the Policyowner's Identity Card/Passport
5. Copy of the Life Insured's Identity Card/Birth Certificate/ Passport, if different from Policyowner's.
6. In event of Payor Benefit Rider Claim, please provide copy of Payor's Identity Card / Passport and proof of relationship if different from Policyowner's.
7. In the case of a Disability Advance Payment Plus Benefit Claim, please provide the last 12 months of Central Provident Fund Contribution Statement or Letter to show the last day of employment service prior to disability.
8. Upon receipt of **ALL** the above required documents, we will process your claim and inform you of the outcome as soon as possible. However, in certain circumstances, we may require further information after the above documents are received.
9. If you need any assistance, please contact our Customer Service Officers at **6833 8188**

**Notes:**

- I. The fee for obtaining the Attending Physician's Statement shall be borne by the life insured/ policyowner.
- II. If you are asking another party to assist in the claim processing, an authorisation letter is required.
- III. Please continue to pay the premiums until the claim is approved.
- IV. If the policy has a nomination under section 73 of the Conveyancing and Law of Property Act, **the proceeds will be payable to the trustee for the benefit of the beneficiary(ies).**
- V. If the policy has a nomination under section 49L of the Insurance Act, **the proceeds will be payable to the trustee of the policy for the benefit of the beneficiary(ies).** If the sole trustee is the policyowner, we are unable to make payment to the policyowner. In this instance,, the policyowner can either appoint another trustee by using a prescribed form to receive the proceeds for the benefit of the beneficiary(ies) or give us instructions to make payment to each beneficiary for his/ her share.

**Notes:**

1. A waiting period of 6 months from the date of disability must elapse before a disability claim will be considered.
2. The insurer does not admit liability by the mere issue of this or any other forms.

Policy No.
Claim No. <small>(For internal use)</small>

**1. PERSONAL PARTICULARS**

Name of Life Insured: \_\_\_\_\_ NRIC/ Passport No: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Tel (O): \_\_\_\_\_  
 Address: \_\_\_\_\_ Tel (H): \_\_\_\_\_  
 \_\_\_\_\_ Mobile: \_\_\_\_\_  
 (Residential Address Only)

**2. DETAILS OF OCCUPATION**

(a) Occupation (Job Title) \_\_\_\_\_  
 Employed     Self Employed

(b) Name of Employer \_\_\_\_\_

(c) Address of Employer \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(d) Monthly Income \_\_\_\_\_

(e) List all the major duties \_\_\_\_\_  
 of your pre-disability \_\_\_\_\_  
 occupation\* (see Note \_\_\_\_\_  
 below) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List the specific duties \_\_\_\_\_  
 you are unable to do as \_\_\_\_\_  
 a result of your disability \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\*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.



(m) Have you in the past worked in any other occupation?  Yes  No

If 'Yes', please provide details.

Occupation	Period	Employers/ Business name	Duties
_____	_____ to _____	_____	_____
_____	_____ to _____	_____	_____
_____	_____ to _____	_____	_____
_____	_____ to _____	_____	_____

(n) Please describe your domestic duties.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(o) If you are self-employed:

(i) What is the structure of your business?

- Sole Trader  Partnership  Company  
 Trust  Others

(ii) How many employees are there in your business?

No. of part-time employees \_\_\_\_\_  
 No. of full-time employees \_\_\_\_\_

(p) Please provide all duties of your pre-disability occupation including percentage of time spent in each.

Duties	Percentage
_____	_____ %
_____	_____ %
_____	_____ %
_____	_____ %

(q) How long have you been in this occupation? \_\_\_\_\_ years \_\_\_\_\_ months

(r) Please indicate below the percentage of your day spent performing the physical activities of your occupation.

Activities	Percentage	Activities	Percentage
Lifting 20kg or over	_____ %	Climbing (Ladders etc)	_____ %
Lifting 7kg or over	_____ %	Bending	_____ %
Carrying 20kg or over	_____ %	Kneeling	_____ %
Carrying 7kg or over	_____ %	Sitting	_____ %
Standing	_____ %		



(e) Are you currently confined to:  bed  house  hospital  Not Applicable

If yes, state the period of confinement. \_\_\_\_\_

If not confined, describe briefly your daily activities.

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(f) Has there been any improvement in your condition? If yes, please describe.

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(g) Have you made any attempt to do any work since the date of disability began? If yes, please give the date you returned to work.

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(h) Are you still totally disabled?  Yes  No

If yes, when do you expect to be able to resume your work, even in a limited way?

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

Name of Physician/ Hospital	Address	Consultation		Admission Dates
		Reasons	Dates	

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

Name of Physician / Hospital	Address	Consultation	
		Reasons	Dates

(a) Have you ever had this medical condition or any other similar condition before?  Yes  No

If yes, please provide the following details.

(i) Date of Diagnosis: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (ii) Period off work: \_\_\_\_\_  
dd mm yyyy

(iii) Name and address of doctor: \_\_\_\_\_  
 \_\_\_\_\_

(b) Please provide details of all medical treatment (including physiotherapy, acupuncture, chiropractic or any other practicing alternative therapies), and consultations in the last 3 years:

(i) Date first consulted \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

Name \_\_\_\_\_ Qualifications \_\_\_\_\_

Address \_\_\_\_\_  
 \_\_\_\_\_

Reason for consultation: \_\_\_\_\_

(ii) Date first consulted \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

Name \_\_\_\_\_ Qualifications \_\_\_\_\_

Address \_\_\_\_\_  
 \_\_\_\_\_

Reason for consultation: \_\_\_\_\_

(iii) Date first consulted \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

Name \_\_\_\_\_ Qualifications \_\_\_\_\_

Address \_\_\_\_\_  
 \_\_\_\_\_

Reason for consultation: \_\_\_\_\_

