



Dear Claimant

We are sorry to learn of the life insured's accident.

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

1. **Personal Accident Claim Form**
2. Medical Certificates.
3. Attending Physician's Statement
4. Police Report, if any
5. Copy of Policyowner's Identity Card / Passport
6. Copy of the Life Insured's Identity Card/Birth Certificate/ Passport, if different from Policyowner.
7. 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.
8. 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 you in the claim process, an authorization letter is required.
- III Please continue to pay the premiums until the claim is approved.
- IV Please note that the Personal Accident Benefit is a rider attached to base plan. Hence, if you have made a nomination under section 73 of the Conveyancing and Law of Property Act or section 49L of the Insurance Act, the nomination on the base plan will apply similarly to the rider. Payment will be made to the trustee for the benefit of the beneficiary(ies). For a nomination under section 49L, payment cannot be made to a trustee who is also the policyowner and sole trustee. In such instance, the policyowner can either appoint another trustee to receive the payment or instruct us to make payment to each beneficiary for his/her share.

- (f) Were there any eye witnesses to the accident? Yes No

If yes, please provide the name(s) and address(s) of witness(es).

Name of Witness	Address

3. DETAILS OF HOSPITALISATION

(a) Period of Hospitalisation: _____

(b) Please provide the names and address of doctor and hospital who first attended to you after the accident.

(c) Please provide the name and address of the doctor now in attendance, if not the same as above.

4. DETAILS OF YOUR DISABILITY

(a) Please provide the date on which you last worked at your present occupation.

(b) Are you now or have you been totally disabled from performing the duties of your own or any other occupation? Yes No

If yes, please state the period of total disability.

From _____ To _____

(c) Are you now or have you been partially disabled to perform only part or some of the duties of your own occupation? Yes No

If yes, please provide us the following details:

(i) Please state the period of partial disability.

From _____ To _____

(ii) Please describe the duties that you were unable to perform.

(iii) Date on which you were able to perform all your duties: _____

5. OTHER INSURANCE(S)

Are you claiming from any other insurance company in respect of this disability? Yes No

If yes, please provide the following information:

Name of Insurer	Policy Number	Policy Effective Date	Type of Plan	Sum Assured	Claim Amount	Claim Notified (Yes/ No)

DECLARATION AND AUTHORISATION

I **declare** that all answers given by me in this form are, to the best of my knowledge and belief, true and complete.

I **consent** to the Company seeking / providing information about me from / to any medical source, insurance office, organisation or person, governmental organisation and / or regulatory body. **A photographic copy of this authorisation shall be as valid as the original.**

I **agree** to bear the fees (if any) payable for any reports obtained for the purpose of processing of this claim. I understand that these reports may not be made available to me and that the Company reserves the right not to release these report(s) or a copy of these report(s) to me. I **give** my consent for the fees to be deducted from the claim that is payable to me, if it is admitted.

Signature of Claimant

Signature of Witness

Name (as per NRIC):

Date:

Name (as per NRIC):

NRIC/ PP No:

Contact No:

Date: