Personal Accident Claim

CLAIMANT'S STATEMENT FORM

* C L A I M F *

Singlife

IMPORTANT NOTES:

1. All sections of our forms must be duly completed to avoid unnecessary delay. Indicate as "N.A." if not applicable.
2. Any fees for completion of the Doctor's Statement and/or medical evidence shall be borne by the person making the claim.
3. The acceptance of this form is not an admission of liability on the part of Singapore Life Ltd. Any documentary proof or report required by Singapore Life Ltd. shall be furnished at the expense of the person making the claim.
4. If you have submitted medical reimbursement claims via the online portal or email, please keep your original bills.

Policy Number

SECTION A: INSURED PERSON DETAILS

Claimant Name (as per NRIC/FIN)

NRIC/FIN/Passport/Birth Certificate Number
*Please attach copy of NRIC/FIN (front and back)

Occupation

Date last at work (dd/mm/yyyy)

Name of Employer

Address of Employer

SECTION B: ACCIDENT DETAILS

Note: For Accident claims, please complete all sections.
For Illness or Infectious Disease claims, please skip to Section C.

Date and time of Accident

Date

Time

Place and Country of Accident

Describe and provide details on how the accident happened, exact area(s) of the body and extent of injuries/disabilities sustained

Was there any eyewitness to the accident? ☐ Yes ☐ No
If "Yes", please provide details below:

Name of Witness

Address

Contact Number

Relationship with Life Assured/Insured Person (if any)

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SECTION B: ACCIDENT DETAILS (continue)

Was the accident reported to the Police? ☐ Yes ☐ No
If "Yes", please provide a copy of the police investigation report and complete the following:

Name of Investigation Officer-in-charge

Police Station (Branch & Address)

Please state the type of treatment(s) provided.

Date of 1st treatment (dd/mm/yyyy)

For Traditional Chinese Medicine (TCM), please provide details below:

Name of the TCM Physician

TCMB Registration Number

Please state the reason if you did not seek treatment immediately after the accident.

SECTION C: INJURY/ILLNESS/INFECTIOUS DISEASE DETAILS

Date symptoms 1st started (dd/mm/yyyy)

Date 1st treated (dd/mm/yyyy)

Describe all the symptoms presented and the nature of the medical condition or disability.

Date 1st consulted doctor for the condition (dd/mm/yyyy)

Name of Doctor 1st consulted

Address

Date of diagnosis (dd/mm/yyyy)

Exact diagnosis

Have you suffered from or received treatment for a similar or related injury/illness/infectious disease? ☐ Yes ☐ No
If "Yes", please provide full details including name and address of doctor consulted and date of consultations, etc.

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SECTION D: OTHER INFORMATION

Period of Hospitalisation **(Please provide copy of hospital bill)**

From (dd/mm/yyyy) | To

Period of Medical Leave given

From (dd/mm/yyyy) | To

Period of Medical Leave for **Light Duties** given

From (dd/mm/yyyy) | To

Was surgery performed? ☐ Yes ☐ No
If "Yes" please provide the details below:

Type of Surgical Operation/Procedure

Date of Operation/Procedure (dd/mm/yyyy)

Name & Address of Doctor/Hospital

Have you returned to work?

☐ Yes If "Yes", when did you return to work? (dd/mm/yyyy)

☐ No If "No", when would you be expected to return to work? (dd/mm/yyyy)

Are you able to perform all duties of your work after the accident/illness? ☐ Yes ☐ No
If "No", please provide the details below:
What are the work duties you are unable to perform?

When are you expected to be able to fully perform all work duties? (dd/mm/yyyy)

Details of Insured Person's doctor(s) consulted for **this injury/illness or any other disorders/conditions**:

Name & Address of Doctor

Reason for Consultation

Treatment Provided

Date of First Consultation (dd/mm/yyyy) | Date of Last Consultation (dd/mm/yyyy)

Are you claiming Medical Expenses/Workman's Compensation from any other source? ☐ Yes ☐ No
If "Yes", please provide the details below:

Name of Insurance Company, Employer, Third Party, etc

Nature of Claim

Amount Claimed | Policy Number

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SECTION E: MOBILITY AID AND AMBULANCE SERVICE REIMBURSEMENT

MOBILITY AID AND AMBULANCE SERVICES REIMBURSEMENT

Please list the following details for each item you are claiming for:

I. Description of Item including Make & Model/Service engaged

Purchase/Service Activation Date (dd/mm/yyyy)

Purchase/Activation Location

Receipts Attached ☐ Yes ☐ No

Amount you are claiming for (SGD)

II. Description of Item including Make & Model/Service engaged

Purchase/Service Activation Date (dd/mm/yyyy)

Purchase/Activation Location

Receipts Attached ☐ Yes ☐ No

Amount you are claiming for (SGD)

III. Description of Item including Make & Model/Service engaged

Purchase/Service Activation Date (dd/mm/yyyy)

Purchase/Activation Location

Receipts Attached ☐ Yes ☐ No

Amount you are claiming for (SGD)

SECTION F: PERSONAL LIABILITY

Please note that any correspondence you receive regarding this incident should be sent to us immediately.

Was the accident due to carelessness, or negligence on your part? ☐ Yes ☐ No

Have you in any way admitted liability? ☐ Yes ☐ No

If any, which Police Officer and Police Station did you report this occurrence?

Names & Address(es) of the other party/parties

Nature of the personal injury sustained by any person

Extent of the damage to the property belonging to the other party/parties

If a claim has been made against you, was the amount of such claim specified? ☐ Yes ☐ No

If "Yes", what is the amount

Please provide additional information, which you consider would help us in dealing with any claim that may be made against you.

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SECTION G: DECLARATION AND AUTHORISATION

☐ I declare that the information provided is, to the best of my knowledge, correct in every detail. I agree that if I have made any false or fraudulent statements or suppress, conceal or falsely state any material facts whatsoever, either now, or in the future, with regard to this claim, the Policy shall be void and all rights of recovery in respect of past or future claims, shall be forfeited.

I/We consent to Singapore Life Ltd. ("Singlife") (and Singlife related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s) and/or managing my/our relationship with Singlife.

I/We also consent to Singlife (and Singlife related group of companies) disclosing and transferring my/our personal data to Singlife (and Singlife related group of companies) and their respective third-party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

I/We have read and understood Singlife's Data Protection Notice which may be found at https://singlife.com/en/pdpa. Singlife's Data Protection Notice may be updated from time to time without notice. I/We am/are aware that I/we should visit your website regularly to ensure that I/we am/are well informed of the updates.

☐ I hereby authorise any hospital physician, other person, who has attended or examined me, to furnish Singapore Life Ltd. (referred to as "Singlife"), or its authorised representatives, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

Name of Claimant

Signature of Claimant

Date (dd/mm/yyyy)

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