* C L A I M F *

PERSONAL ACCIDENT CONTINUITY CLAIM - CLAIMANT'S STATEMENT
(Further claim submission to a previous claim)

IMPORTANT: Please read the following before completing this form.

1. This claim form is only applicable for **continuity claim** to a previous claim.
2. All sections of our forms must be duly completed to avoid unnecessary delay. Indicate as "N.A." if not applicable.
3. Where softcopies are submitted to us, please retain the original document for at least 6 months as we may request to sight the original copy.
4. Any fees for completion of Doctor's Statement and/or medical evidence shall be borne by the Claimant(s).
5. All overseas documents must be certified by a Notary Public of the Country where documents are produced.
6. All documents must be in English. Any documents which are in foreign languages must be officially translated to English by a certified translator/interpreter.
7. Please provide the following documents (where applicable):
   a) Copy of the Inpatient Discharge Summary
   b) Copy of any diagnostic reports, radiology, X-ray reports, laboratory evidence and any relevant hospital reports
   c) Copy of all medical leave certificates by the Life Assured/Insured Person's employer for continuity claim under Weekly Income Cover
   d) Copy of final hospital / medical invoices and receipts (Interim invoices are not acceptable)
   e) Copy of claim settlement letter and payment voucher if there was a reimbursement of medical expenses from another insurance policies (if any)
8. The Life Assured/Assured will be responsible for the accuracy and integrity of the information provided. Failure to provide details or disclose all relevant information may delay the claim assessment.
9. 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 us shall be furnished at the expense of the claimant.
10. Please continue to pay your premium until we have informed you the outcome of your claim.

A. CLAIM DETAILS

POLICY NUMBER(S):

Name of Life Assured		NRIC / FIN / Passport / Birth Certificate No.
Date of Accident (dd/mm/yyyy)	Date of Diagnosis (dd/mm/yyyy)	Date of **First** Hospital admission (dd/mm/yyyy)

Please give details of the Life Assured's **current** physical defects or infirmities

Has the Life Assured returned to work? ❒ Yes ❒ No

If "Yes", please state the date return to work? (dd/mm/yyyy)

Is the Life Assured 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

B. DETAILS OF PERSON SUBMITTING THIS FORM

Name of Assured / Financial Adviser *	
Date	Mobile No.
Email	

* Please delete whichever is not applicable

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