AVIVA LTD
4 Shenton Way #01-01, SGX Centre 2, Singapore 068807
Telephone: 6827 7988 Fax: 6827 7900 Company Reg. No. 196900499K

DISABILITY INCOME CLAIM FORM - CLAIMANT'S STATEMENT

CLAIMS PROCEDURE

1. Life Assured to complete and return this Claimant's Statement to Claims Department at least sixty (60) before the expiry of the Deferred Period of Total Disability Benefit.
2. Life 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.
3. The medical reports fees (if any) will be borne by the Life Assured.
4. Please continue to pay your premium until we have informed you the outcome of your claim. We advise that Aviva Ltd does not admit liability by the mere issue of this or any other form.

Policy Number: ____

A. DETAILS OF LIFE ASSURED

1. Name of Life Assured	I.C./Passport/B.C. No.	Date of Birth	
Home Address:	Marital Status:	Gender:	Religion:
Home Tel No.:	Mobile No.:	Office Tel No.:	
2. Name of Assured (if different from Life Assured):	I.C/ Passport No:	Gender:	Date of Birth:

B. DETAILS OF EMPLOYMENT

1. Were you gainfully employed at the time of your Disability? ***YES / NO***

   (a) If "Yes", please proceed to Q2

   (b) If "No", please proceed to Q9

2. Your Occupation:

3. Date you first commenced the occupation:

4. Please describe the **material duties** involved in your occupation, starting with the task you do most. You should include all significant tasks requiring physical mobility (e.g. lifting/ carrying) and also the need to work on your feet for significant periods.

Details	**Percentage of Your Working Hours**
Duty 1 …………………………………………………………………………………………	(%)
Duty 2 …………………………………………………………………………………………	(%)
Duty 3 …………………………………………………………………………………………	(%)
Other Duties: ……………………………………………………………………………………	(%)
…………………………………………………………………………………………………	(%)

5. (a) State your average monthly Earned Income in the 12 months before date of Disability.

    S$………………………….. (Please support with documentary evidence, such as salary slips, Income Tax Returns, letter from employer, etc.)

   (b) How much of this Earned Income had been lost as a result of your Disability? S$ ………………………..

6. Date you last worked:

7. Name and address of the employer.

8. Are you holding more than one occupation? ***YES / NO***
   If "Yes, please state your other occupation and describe the material duties involved in that occupation as in Question 4 above.

(Please Proceed to Question 12)

9. Date you ceased being gainfully employed:

10. State your last occupation and describe your duties.

11. Date you first commenced the last occupation:

12. Are you following any occupation(s) on either full-time or part-time basis since you first become disabled? ***YES / NO.*** If "Yes", please advise:

    (a) Nature of Occupation:

    (b) Date you start work:

    (c) Salary per month:

    If "No", please advise:

    (a) Reason:

    b) Date you expect to be able to return to work:

C. DETAILS OF DISABILITY

1. If your Disability is due to ***sickness***, describe in details all symptoms and the nature of Disability suffered.

2. Date you first noticed symptoms:

3. Have you previously suffered from Disability of this nature? ***YES / NO***
   If "Yes", please elaborate with dates, name of doctors consulted and name and address of clinic / hospital.

4. If your Disability is resulted from ***accident***, please describe:

   (a) Date and Time of accident:

   (b) (i) Describe in detail how the accident happened:

   (ii) Nature and Extent of injuries sustained:

5. Date your Disability ***totally*** prevented you from performing the material duties of your occupation:

6. State you present daily activities:

7. Details of doctor(s) you have consulted for this ***present*** Disability.

Name of Doctor	Name and Address of Clinic/ Hospital	Date first and last consulted
..………………………	…………………………………………………………	…………………/…………………..
………………………..…	………………………………………………………….	…………………/…………………..
………………………..	…………………………………………………………	…………………/…………………..
………………………..	…………………………………………………………..	…………………/…………………..

8. Have you been hospitalised for condition(s) related to your Disability? ***YES / NO***
If "Yes", please advise:

Name of Hospital	Date of Admission	Date of Discharge	Type of Surgery, if any
……………………………	………………………	………………………	…………………………
……………………………	………………………	………………………	…………………………

9. If as a result of your Disability, you have been:

(a) Confined to your bed, please advise date of confinement from …………………… to ………………………

(b) Confined to your house, please advise date of confinement from …………………… to ………………………

10. Details of doctor(s) you consulted for any ***other*** disorders in the past 3 years.

Name of Doctor	Name and Address of Clinic/ Hospital	Reasons for Consultation
………………………………	……………………………………………..	……………………………………………….……
………………………………	……………………………………………..	……………………………………………….………
………………………………	……………………………………………..	…………………………………………………………

D. OTHER SOURCES OF INCOME

1. Give details of any salary, remuneration, or benefit you are receiving or expect to receive because of or during your Disability from employer or from any other source.

Source	Amount S$….monthly/ yearly	Date of Commencement of payment	Date of Termination of payment
…………………………………..	…………………………….	………………………………..	………………………………
…………………………………..	…………………………….	………………………………..	………………………………
…………………………………..	…………………………….	………………………………..	………………………………

E. OTHER INSURANCES

1. Are you claiming or receiving from any other insurance company or other source in respect of this Disability?
YES / NO. If " Yes", please furnish details

Name of Insurer/ other source	Type of plan	Date of Issue	Sum Assured	Claim Amount
……………………………………	……………………	……………………	…………………	……………….
……………………………………	……………………	……………………	…………………	……………….
……………………………………	……………………	……………………	…………………	……………….

E. DECLARATION AND AUTHORISATION

I, ……………………………………………….…....…….(NRIC/PP No. …….…………………….) declare that the answers given by me in this Form are in every respect true and correct and that no material information has been withheld nor any relevant circumstances omitted.

I further consent to Aviva Ltd seeking information from any clinic, hospital, physician, person, organisation, employer that may be required in connection with this claim and I authorise the giving of such information to Aviva Ltd. A photocopy of this authorisation shall be considered as effective and valid as the original.

Signature of Witness …………………………………	Signature of Life Assured : …………………………………………
Name of Witness : …………………………………	Name of Life Assured : …………………………………………
Address : ………………………………….	Address : …………………………………………
…………………………………….	…………………………………………
Telephone : …………………………………..	Telephone : ………..………………………………..
Date : …………………………………..	Date : …………………………………………