



**GROUP LIFE & HEALTH CLAIMS  
TOTAL AND PERMANENT DISABILITY CLAIM FORM  
CLAIMANT'S STATEMENT**



SINGAPORE LIFE LTD.  
Group Life & Health Claims  
5 Straits View, #01-18/19  
Marina One The Heart, Singapore 018935  
Tel: 6827 8030  
Company Registration No.196900499K

The insurer does not admit liability by the mere issue of this form.

Name of Company: \_\_\_\_\_ Policy No: \_\_\_\_\_

**SECTION I (TO BE COMPLETED BY CLAIMANT)**

1. PERSONAL PARTICULARS			
Name of Claimant	NRIC/Passport	Date of Birth (DD/MM/YY)	Gender <input type="checkbox"/> F <input type="checkbox"/> M
Email Address	Mobile No	Marital Status	
Present Address:			
Date of Employment (DD/MM/YY):		Commencement Date of Insurance (DD/MM/YY):	
2. DETAILS OF OCCUPATION			
Occupation	Before Disability	After Disability	
Average Monthly Income (Please furnish a copy of last payroll)			
List exact duties performed at work *			
* If you are not working, please provide a list of daily activities before and after the disability. Singapore Life Ltd. reserves the right to request for documentary evidence.			
3. DETAILS OF DISABILITY			
a) Is this disability suffered due to:	<input type="checkbox"/> Illness (Date of Symptoms Started)	<input type="checkbox"/> Accident (Date / Time of Accident)	
b) Describe in details all symptoms and/or nature of injuries / disability suffered			
c) Date of last work:	d) Are you currently confined to: <input type="checkbox"/> Bed <input type="checkbox"/> Home <input type="checkbox"/> Neither		
e) Date you return to work _____ OR date you expected to return to work _____			
4. DETAILS OF PHYSICIAN(S) CONSULTED OR HOSPITAL(S) ADMITTED FOR THIS DISABILITY			
Name (s)	Address (es)	Admission Date (s)	



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5. DETAILS OF YOUR REGULAR PHYSICIAN OR ANY OTHER PHYSICIAN(S) CONSULTED FOR ANY OTHER DISORDERS IN THE PAST THREE YEARS		
Names(s)	Address(es)	Admission Date(s)

6. OTHER CLAIMS		
Are you claiming from any other insurance company or other sources in respect of this disability? If Yes, please provide the following information:		
Name of Company	Amount Claimed	Policy No (if applicable)

**AUTHORISATION & CONSENT**

This part must be signed by the patient's parent / legal guardian if the patient is below 21 years old.

I/We hereby authorise any hospital, physician, person or organization to disclose when requested to do so by Singapore Life Ltd. ("Singlife"), any and all information with respect to any illness, or injury, medical history, consultations, prescriptions or treatment and copies of all hospital or medical records. A photostat copy of this authorisation shall be considered as effective and valid as the original.

I/We hereby authorise Singlife to request from any hospital, physician, person or organisation, all information with respect to any.

I/We declare and undertake that I/we have submitted the actual bills and receipts (including electronic/digital copies) issued by the medical institutions.

I/We understand that Singlife has the right to:

- 1 Ask for originals/certified true copies of the bills and receipts, or contact the medical institution directly, to confirm that the bills and receipts are original.
- 1 Reject claims, recover amounts paid or impose additional charges, if the claim is false or where there are multiple claims made.

I/We declare that the statements and answers stated are true and complete to the best of my/our knowledge and belief.

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) 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 Policy which may be found at [www.singlife.com/pdpa](http://www.singlife.com/pdpa). Singlife's Data Protection Policy 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.

Signature of Claimant: \_\_\_\_\_ Date: \_\_\_\_\_

**(TO BE COMPLETED BY ASSURED COMPANY)**

2) If Sum Assured is Based on Salary, please furnish a Certified True Copy (by employer) of the Insured Member's last pay slip (for a full month)

a) Last Drawn Salary:	b) Date of Last Drawn Salary:

_____	_____	_____
Signature of Employer	Company's Name / Stamp	Date



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**SECTION II (TO BE COMPLETED BY ATTENDING PHYSICIAN AT INSURED'S EXPENSE)**

Name of Patient: _____		NRIC/Passport No: _____
<b>PART A - PATIENT'S CONDITION</b>		
<b>1. CONSULTATION FOR PRESENT ILLNESS / INJUR(IES)</b>		
a) Are you the patient's usual physician? <input type="checkbox"/> Yes <input type="checkbox"/> No      If Yes, since what date? _____		
b) When did the patient first consult you for this illness or injur(ies)? _____		
c) Please provide details on:		
i) Symptoms presented _____		
ii) Duration of these symptoms _____		
iii) Diagnosis _____		
iv) Date of Diagnosis _____		
v) Was the diagnosis made known to the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No      If Yes, when? If No, why? _____		
d) If consultation was for injur(ies), please describe injuries: _____		
<b>2. Please describe treatment, including any operations performed.</b> _____ _____ _____		
<b>3. If the patient was referred from a clinic or hospital, please state:</b>		
a) Name of Physician: _____		
b) Name of Clinic/Hospital: _____		
c) Date Referred: _____		
<b>4. Has patient been admitted to hospital before for the same illness/injur(ies)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No      If Yes, please state		
a) Date admitted _____		b) Date discharged _____
c) Name of hospital _____		d) Admission No _____
<b>5. Has the patient suffered or is suffering from any other disease or ailment? If so, please give details</b> _____ _____ _____		
a) Date patient first suffered from the disease or ailment _____		
b) Name and address of Physician consulted _____		



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6. Based on your assessment on the patient, please indicate below what best to describe the patient's disability status:

- Good recovery – can lead a full and independent life with or without minimal neurological deficit.
- Moderately disabled – has neurological or intellectual impairment but independent.
- Severely disabled – conscious but totally dependent on others to get through daily activities.
- Vegetative survival.

7. Is the patient able to return to his/her usual occupation?

- If Yes, please elaborate when can he/she return to work and what is the limitation?  
\_\_\_\_\_

- If No, please elaborate to what extend does his/her disability prevent him/her from performing all the normal duties of his/her usual occupation? When can he/she return to work, what is his/her limitation?  
\_\_\_\_\_

- What other type of occupation can the patient perform?  
\_\_\_\_\_

8. In your opinion, would the patient's condition lead to death within the next 12 months from the date of diagnosis?  
\_\_\_\_\_

9. Please provide us with any other additional information that will enable the company to assess this claim.  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Physician / Surgeon

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name / Designation

\_\_\_\_\_  
Name and Address of Clinic / Hospital & Stamp



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PART B – ACTIVITIES OF DAILY LIVING				
Please comment on whether the patient is able to perform the following activities of daily living:				
Activity	Score			
<b>Feeding</b> 0 = unable 5 = need help cutting, spreading butter, ect., or require soft diet 10 = independent	<input type="checkbox"/> 0	<input type="checkbox"/> 5	<input type="checkbox"/> 10	
<b>Bathing</b> 0 = dependent 5 = independent (or in shower)	<input type="checkbox"/> 0		<input type="checkbox"/> 5	
<b>Grooming</b> 0 = needs to help with personal care 5 = independent [( face / hair / teeth / shaving (implements provided)]	<input type="checkbox"/> 0		<input type="checkbox"/> 5	
<b>Dressing</b> 0 = dependent 5 = need help but can do about half unaided 10 = independent (including buttons, zip, laces, ect)	<input type="checkbox"/> 0	<input type="checkbox"/> 5	<input type="checkbox"/> 10	
<b>Bowels</b> 0 = incontinent (or needs to be given enemas) 5 = occasional accident 10 = continent	<input type="checkbox"/> 0	<input type="checkbox"/> 5	<input type="checkbox"/> 10	
<b>Bladder</b> 0 = incontinent or catheterised and unable to manage alone 5 = occasional accident 10 = continent	<input type="checkbox"/> 0	<input type="checkbox"/> 5	<input type="checkbox"/> 10	
<b>Toilet Use</b> 0 = dependent 5 = needs some help, but can do something alone 10 = independent (on and off, dressing, wiping)	<input type="checkbox"/> 0	<input type="checkbox"/> 5	<input type="checkbox"/> 10	
<b>Transfer (bed to chair and back)</b> 0 = unable, no sitting balance 5 = major help (one or two people, physical), can sit 10 = minor help (verbal or physical) 15 = independent	<input type="checkbox"/> 0	<input type="checkbox"/> 5	<input type="checkbox"/> 10	<input type="checkbox"/> 15
<b>Mobility (on level surfaces)</b> 0 = immobile or < 50 yards 5 = wheelchair independent, including corners > 50 yards 10 = walks with help of one person (verbal or physical) > 50 yards 15 = independent (but may use any aid; for example, stick) > 50 yards	<input type="checkbox"/> 0	<input type="checkbox"/> 5	<input type="checkbox"/> 10	<input type="checkbox"/> 15
<b>Stairs</b> 0 = unable 5 = needs help (verbal, physical, carrying aid) 10 = independent	<input type="checkbox"/> 0	<input type="checkbox"/> 5	<input type="checkbox"/> 10	
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p style="text-align: center;">_____ Signature of Physician / Surgeon</p> <p style="text-align: center;">_____ Name / Designation</p> </div> <div style="width: 45%;"> <p style="text-align: center;">_____ Date</p> <p style="text-align: center;">_____ Name and Address of Clinic / Hospital &amp; Stamp</p> </div> </div>				