Singlife

LIVING & DISABILITY BENEFIT CLAIM FORM

IMPORTANT: Please read before completing this claim form.

1. Please click on "Find out more" in the specific claim's section via www.singlife.com/claims to read the instructions before completing this form.
2. 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.
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 us shall be furnished at the expense of the claimant.
4. Please continue to pay your premium until we have informed you the outcome of your claim.

A. Details of Policy

Policy Number(s)

Type of Claim **(please tick (√) the appropriate box)**

- ❐ Critical Illness (Cognitive Care Benefit / Mental Care Benefit)
- ❐ Total & Permanent Disability
- ❐ Terminal Illness
- ❐ Disability Income
- ❐ Maternity Benefit for Mother / Child

B. Details of Life Assured and Assured

Details of Life Assured

Name of Life Assured				NRIC / FIN / Passport / Birth Certificate Number	
Date of Birth (dd/mm/yyyy)		Gender		Marital Status	
Name and Address of Employer				Occupation	

Details of Assured

Name of Assured		NRIC / FIN / Passport Number	
Email		Contact Number	

Residential Address*

Postal Code

Country

* **Note:** All communication will be sent to the contact information (address, email or phone number) registered with us. Please log into https://mysinglife.singlife.com/account/login to update your contact details if there are any changes.

C. Details of Illness / Disability

1) Exact Diagnosis		2) Date of Diagnosis (dd/mm/yyyy)	
3) Describe **First** Symptoms Presented		4) Date of **First** Symptoms (dd/mm/yyyy)	
5) Name and Address of **First** Doctor Consulted for the Symptoms		6) Date of **First** Consultation (dd/mm/yyyy)	

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7) Please provide the details of all the doctor(s) consulted for this illness/disability:

Name(s) and Address(es) of Doctor(s)	Date of **First** Consultation (dd/mm/yyyy)	Date of **Last** Consultation (dd/mm/yyyy)	Reason(s) for Consultation	Treatment(s) Provided

8) Please provide the details of all family / regular / company doctor(s) consulted for minor ailments (eg Flu, Fever, Cough), Diabetes Mellitus, Hypertension (High Blood Pressure), Hyperlipidemia (High Cholesterol) and any other condition(s):

Name(s) and Address(es) of Doctor(s)	**First** Consultation (dd/mm/yyyy)	**Last** Consultation (dd/mm/yyyy)	Reason(s) for Consultation	Treatment(s) Provided

9) Is the Life Assured currently confined to (please tick (√) the appropriate box):

❒ Not confined ❒ Bed ❒ House ❒ Hospital ❒ Others (please specify) ______________________

If the Life Assured is confined, please state the date confinement **first** started (dd/mm/yyyy):

10) Is the Life Assured hospitalised? ❒ Yes ❒ No

If "Yes", please provide the details:

Hospitalisation Period (including Intensive Care Unit (ICU))		Hospitalisation Period in Intensive Care Unit (ICU)	
Admission Date (dd/mm/yyyy)	Discharge Date (dd/mm/yyyy)	Admission to ICU (dd/mm/yyyy)	Discharge from ICU (dd/mm/yyyy)

11) Has the Life Assured returned to work?

❒ Yes – Please state the actual date of return to work (dd/mm/yyyy):

❒ No – Please state the intended date to resume to work (dd/mm/yyyy):

12) Daily activities before and after illness/disability:

a. List the daily activities the Life Assured engaged in **before** this illness/disability:

b. List the daily activities the Life Assured currently engages in **after** this illness/disability:

c. Please elaborate on what is preventing the Life Assured from performing the daily activities he/she used to engage in before this illness/disability:

13) Is the Life Assured claiming / intending to claim from any other Insurance Company(ies) or other sources i.e. employer, Work Injury Compensation Act (WICA) and etc? ❒ Yes ❒ No

If "Yes", please provide the details:

Name of Insurance Company / Other Sources	Policy Number	Type of Plan	Date of Issue (dd/mm/yyyy)	Claim Amount	Claim Settled (Yes / No)

D. Mode of Payment

For a better payment experience, Individual Life (i.e. non-corporate policies) SGD payments to the Assured will be credited to the bank account linked to the Assured's PayNow-NRIC/FIN. Please ensure that you have registered for PayNow using your NRIC/FIN.

Bank Account Details (ONLY Applicable for Corporate Policyholders)

Name of all Bank Account Holder(s)	
Name of Bank	Bank Account Number

Note: For Corporate Policyholders, please provide us with a copy of their bank passbook/statement with full name, bank name and account number clearly indicated on the same page. All other information may be blanked out.

E. This section is applicable for product with Advance Care Option only.

1. Assuming that the Life Assured meets the requirements for the Advance Care Option, does the Assured wish to exercise the Advance Care Option?

   ❒ Yes, I wish to exercise and accept the Advance Care Option under the policy if it fulfils the terms and conditions of the policy. I understand that the Recurrent Critical Illness Benefit shall cease upon exercising this Option. I understand that this Option can only be exercised once and it cannot be reversed. I agree that the acceptance of the payment (if any) shall be in full and final settlement of any claims or demands upon Singapore Life Ltd. arising under the said benefit and the receipt of the said sum (if any) by me shall serve as a final discharge to Singapore Life Ltd.

   ❒ No, I do not wish to exercise the Advance Care Option. I understand that the Recurrent Critical Illness Benefit shall remain in force and the Advance Care Benefit will no longer be available under the Basic Benefit.

Note: By indicating your preference above, you acknowledge that the Advance Care Option will only be processed if the claim is admitted and you are contractually entitled to exercise the Option under the policy. Singapore Life Ltd. reserves the right to request further confirmation in the processing of the Option.

F. This section is applicable for Disability Income Insurance Benefit only.

1. Was the Life Assured performing **any** work or engaged in an occupation/profession **at the time of disability**?

   ❒ Yes – Please complete all questions in this section.

   ❒ No – Please complete Q1a to Q1f based on the **last** occupation, and Q8 to Q9.

   a. Job Title:

   b. Name and Address of Employer:

   c. Employment Type

   ❒ Full-Time ❒ Part-Time ❒ Contract ❒ Temporary ❒ Self-Employed

   d. Date Employment Started (dd/mm/yyyy):

   e. Date of **Last** Day Worked (dd/mm/yyyy):

   f. Describe the **material duties** involved in the occupation, beginning with the task he/she did most.

   Please also include all **significant** tasks that require physical strength (e.g. lifting, carrying or standing for significant periods).

Details	Percentage of Working Hours	Details	Percentage of Working Hours

2. Date which the condition had totally and permanently prevented the Life Assured from performing the material duties of the occupation (dd/mm/yyyy):

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3. State the Life Assured's average monthly earned income in the 12 months before the start of disability. **Please attach documentary evidence, such as salary slips, IRAS income tax statement, letter from employer, etc.**	SGD
4. How much of this earned income has been lost because of the disability?	SGD

5. Was the Life Assured holding more than one (1) occupation at the time of disability? ❒ Yes ❒ No

If "Yes", please provide details of every occupation the Life Assured held in the last twelve (12) months prior to disability by **answering all the question 1. to 4.** on a separate piece of paper.

6. Is the Life Assured unable to perform the material duties of his/her occupation due to the disability? ❒ Yes ❒ No

7. Is the Life Assured currently performing **<u>any</u>** work or engaged in an occupation/profession suited to his/her training, education, or experience **<u>after the disability</u>**? ❒ Yes ❒ No

If "Yes", please state the **<u>current</u>** occupation details:

a. Job Title:

b. Name and Address of Employer:

c. Date the Life Assured Started Work (dd/mm/yyyy):

d. Monthly Salary (SGD):

e. Describe the **material duties** involved in the occupation, beginning with the task he/she did most. Please also include all **significant** tasks that require physical effort (e.g. lifting, carrying or standing for extended periods).

Details	Percentage of Working Hours	Details	Percentage of Working Hours

8. What academic or work-related qualifications does the Life Assured hold?

S/No.	Qualification	Date Acquired (dd/mm/yyyy)

9. Please provide details of any benefit, salary, or remuneration the Life Assured is receiving or expects to receive from any sources ie employer, other insurance company, government, pension scheme and etc.

Source	Amount and Frequency of Payment	Date Payment Starts (dd/mm/yyyy)	Date Payment Ceases (dd/mm/yyyy)
	S$ per		
	S$ per		

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G. Declaration of Beneficial Owner, FATCA and CRS

Declaration of Beneficial Owner

Note: This is only applicable if the recipient of the proceeds is a legal person or a legal arrangement.

❒ I/We declare that there is no change in Beneficial Owner(s).

Otherwise, please submit the "Declaration of Beneficial Owner Form" together with this form if there is any change in the Beneficial Ownership. You may find the Declaration of "Beneficial Owner Form" on our website www.singlife.com.

"Beneficial Owner" means the natural person who ultimately owns or controls the customer or the natural person on whose behalf business relations are established and includes any person who exercises ultimate effective control over a legal person or legal arrangement.

"Legal person" means an entity other than a natural person that can establish a permanent customer relationship with a financial institution or otherwise own property.

"Legal arrangement" means a trust or other similar arrangement.

Declaration of US person status under the Foreign Account Tax Compliance Act (FATCA)

Note: US Indicia means a US citizen or resident; born in US; have a US taxpayer ID number; current US mailing or residence address (including a US post office box); current US telephone number; currently give standing instructions to transfer funds to an account maintained in the US; currently give effective power of attorney or signatory authority granted to a person with a US address; or have a US "in-care-of" or "hold mail" address).

Please tick (√) the box as appropriate.

❒ I/We declare and agree that there is no change to my tax status and I am/We are not a "US Person" for US federal income tax purposes and that I am/We are not acting for, or on behalf of a US person. I/We understand that Singapore Life Ltd., believing this statement to be true, will rely and act on it.

❒ I/We declare and agree that I/We have one or more US indicia but I am/We are not a "US Person" for US federal income tax purposes and that I am/We are not acting for, or on behalf of a US person. I/We understand that Singapore Life Ltd., believing this statement to be true, will rely and act on it.
(If you have selected this option, please complete the **United States of America (US) Person Declaration form** (available at www.singlife.com/fatca) and return to us.

❒ I/We declare and agree that I am/We are a "U.S. Person" for U.S. federal income tax purposes.
(If you have selected this option, please complete the **United States of America (US) Person Declaration form** (available at www.singlife.com/fatca) and return to us.

I/We understand that Singapore Life Ltd. is required to provide to any governmental authority including the Inland Revenue Authority of Singapore (IRAS) and/or the US Internal Revenue Service (IRS), with information on US persons who may have received proceeds under cash value insurance contracts or annuity contracts with certain prescribed amount at any time during the calendar year. I/We agree that if my/our tax status has changed to a US tax status and/or I/We have become US citizen(s) or resident(s), I/We will notify Singapore Life Ltd. within 30 days of the change.

Warning: Please note that providing false or misleading information is an offence under the Singapore Income Tax Act 1947.

Declaration of Tax Residency under the Common Reporting Standard (CRS)

Please tick (√) the box as appropriate.

❒ I/We declare that there is no change to the information that I/We have provided to Singapore Life Ltd. that would result in a change to my/our tax residency status, such as change in my/our residence/mailing/in-care of address and telephone number.

❒ I/We declare that there is a change(s) to the information that I have provided to Singapore Life Ltd. that would result in a change to my/our tax residency status, such as change in my/our residence/mailing/in-care of address and telephone number.
(If you have selected this option, the **CRS Self-Certification Form for Individual/Entity/Controlling Person (whichever is applicable)** (available at www.singlife.com/CRS) and return to us.

I/We declare that I am/We are the Account Holder (or am authorized to sign the Account Holder) of all account(s) to which to this form relates. I/We undertake to notify Singapore Life Ltd. within 30 days of any change in circumstances which affect my/our tax residency status or cause the information contained herein to become incorrect or incomplete, and to provide Singapore Life Ltd. a suitably updated self-certification form and declaration within 90 days of such change in circumstances.

For the purposes of this section, Account Holder means the person listed or identified as the policy owner of the policy. A person holding a policy for the benefit of another person as an agent, custodian, nominee, signatory, advisor, intermediary or as a legal guardian is not treated as the Account Holder.

Warning: Please note that providing false or misleading information is an offence under the Singapore Income Tax Act 1947.

H. Declaration and Authorisation

Name of Life Assured		Identity Number of Life Assured	

I/We hereby declare that the answers given by me/us in this Form are in every respect true and correct and that no material information or circumstance has been withheld or omitted.

I/We declare that I am/We are not an undischarged bankrupt. There are currently no actual or pending bankruptcy proceedings against me/us and I/We have not assigned the Policy to any other party.

I/We agree that:

a) this claim signifies my/our consent to Singapore Life Ltd. to obtain medical information from any doctor whom the Life Assured has consulted and I/We authorise the doctor to release such information to Singapore Life Ltd.
b) Singapore Life Ltd. may release any relevant information concerning the Life Assured (including medical information) to any third party, which Singapore Life Ltd. deems necessary.
c) any third party who has received any information concerning the Life Assured may also obtain medical information from any doctor whom I/We have consulted, and I/We authorise the doctor to release such information to the third party. The third party may also release relevant information concerning the Life Assured (including medical information) to any other party for any purposes related to the Life Assured's application or my/our claim for the benefits.
d) a photocopied copy of this form shall be treated as valid and binding as if it is the original.

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 www.singlife.com/pdpa. Singlife's Data Protection Notice may be updated from time to time without notice. I am aware that I should visit your website regularly to ensure that I am well informed of the updates.

Note:

1) If you are filling up this form on behalf of another person or whereby you are disclosing personal data to us other than yours, you are required to inform such person(s) of the purpose and obtain his/her consent before submitting this form to us. Once you have submitted, you will be deemed to have obtained the necessary consent for us. Further, you understand that you will be responsible to Singlife for any loss or claim arising out of your failure to obtain consent of the person whose information you have disclosed.

2) If the Assured has been assessed by a doctor to lack mental capacity*, the Assured's appointed Donee(s)/Deputy(s), or Next of Kin if a Donee(s)/Deputy(s) has not been appointed, is to complete this section and sign. The mentally incapacitated Assured need not sign off/affix thumbprint.

   *A separate doctor's memo should be submitted to indicate that the Assured lacks mental capacity, including the relevant medical reason(s).

Signature / Thumbprint / Company's Stamp (if applicable)	Date (dd/mm/yyyy)
Name of Assured	
NRIC / FIN / Passport Number	
Signature of Life Assured aged 21 years or above (if different from Assured)	Date (dd/mm/yyyy)

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