**AIA SINGAPORE**
**CITIBANK CREDIT INSURE**
**TOTAL & PERMANENT DISABILITY / TOTAL & TEMPORARY DISABLEMENT CLAIM FORM**
**Corporate Solutions**

3 Tampines Grande, #07-00, AIA Tampines, Singapore 528799, Fax: 6538 5603 / 6538 4340, Email : sg.eb.claims@aia.com

## CLAIMS PROCEDURES

Please furnish the following documents within 90 days from the date Total & Permanent Disability (TPD) / Total & Temporary Disablement (TTD) is certified and confirmed by a Medical Practitioner :-

a) Duly completed Claimant's Statement (to be completed by the Insured Person / Claimant / Next-Of-Kin)

b) Duly completed Physician's Statement by the Attending Physician / Surgeon. The cost of such report will be borne by the Insured Person / Claimant / Next-Of-Kin.

c) Copy of MRI / CT Scan / Histology / X-ray / Laboratory Reports.

d) Certified True Copy of the police report if Total & Permanent occurred due to an accident.

e) Copy of Claimant's / Next-Of-Kin's identity card* (front and back)

f) Copy of Claimant's/Next-Of-Kin's proof of relationship to the Insured Person* (For example: Marriage Certificate/Birth Certificate/Letter of Administration/Grant of Probate).

g) Copy of Citibank Billing Statement prior to date of event and copy of the Billing Statement for the following 2 months.

h) Any other documents required, will be based on the case itself.

i) Every question must be distinctly and fully answered. The company reserves the right to pursue or obtain further information / document should it be deemed necessary.

j) For details of complete Coverages, Exclusions and any other terms and conditions, please refer to your Credit Insure Certificate.

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## Section 1 - Claimant's Statement

| **Part A : To be completed by Insured Person / Claimant / Next-Of-Kin** | |
|---|---|
| Name of Claimant / Next-Of-Kin | Claimant's / Next-Of-Kin's NRIC / Passport No. |
| Relationship to Insured Person | Contact No. |
| Address of Claimant / Next-Of-Kin | |
| Name of Insured Person | NRIC / Passport No. |
| Date of Birth (DD/MM/YY) | Gender<br>☐ Female ☐ Male |
| Personal Email Address | Contact No. |
| Address of Insured Person for Correspondence | |

| **Part B : Credit Facilities Details** | | |
|---|---|---|
| Credit Card No. | Credit Limit | Coverage Commencement Date |
| Credit Card No. | Credit Limit | Coverage Commencement Date |
| Credit Card No. | Credit Limit | Coverage Commencement Date |
| Others | Credit Limit | Coverage Commencement Date |

| **Part C : Details of Occupation and Benefit** | | |
|---|---|---|
| 1. | Cause of disability | ☐ Accident ☐ Illness |
| | Date of accident / symptoms of illness first started | |
| | Occupation (at time of disability) | |
| | Employer (at time of disability) | |
| 2. | What date did you stop all work? (DD/MM/YY) | Are you currently confined to bed or house?<br>☐ Yes ☐ No If Yes, please specify: |
| 3. | When did you return to work? (DD/MM/YY) | If not, give expected date of return. (DD/MM/YY) |

| 4. | Occupation Details | Occupation | Date of Last Worked | Scope of Duties performed in Job |
|---|---|---|---|---|
| | Before Disability | | | |
| | After Disability | | | |

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5. Name and address of all physicians consulted or hospitals confined for disability:

| Name of Physician | Address | Date of Attendance | Disease or Condition |
|---|---|---|---|
| | | | |
| | | | |

6. Have you ever been or are you at present insured for disability benefits with any other company? ☐ Yes ☐ No
If Yes, please provide the following information:

| Name of Companies | Policy Number | Amounts of Assurance |
|---|---|---|
| | | |
| | | |

## Part D : Declaration and Authorisation

1) I/We acknowledge and accept that the furnishing of this form, or of any other forms supplemental thereto, by AIA Singapore Private Limited ("AIA Singapore") is neither an admission that there was any insurance in force on the life in questions, nor an admission of liability nor a waiver of any of its rights or defences.

2) I/We
   a) hereby declare that I/we are duly authorised to make this claim and all statements and responses whether on this form or otherwise together with any required questionnaire, amendments, materials and supporting documents submitted in connections with the claim and the Policy ("Information");
   b) declare that all information is complete, true and correct and that no information or materials have been withheld and that AIA Singapore will rely and act on the Information accordingly. Otherwise, AIA Singapore shall be at liberty to deny liability or recover amounts paid whether wholly or partially;
   c) acknowledge and accept that AIA Singapore shall be a liberty to deny liability or recover amount paid, whether wholly or partially, if any of the information is incomplete, untrue or incorrect in any respect of if the Policy does not provide cover on which such claim is made; and
   d) acknowledge and accept that AIA Singapore expressly reserves its rights or obtain further information as it deems necessary.

3) I/We hereby authorize, agree and consent to AIA Singapore to request from any hospital, physician, person or organization, all information with respect to any illness, injury, medical history, and copies of all hospital or medical records concerning myself at any time and authorize the prior mentioned organizations to disclose all such information to AIA Singapore.

4) I/We consent to AIA Singapore, its associated persons/organisations, third party service providers and representatives, whether within or outside Singapore (collectively "**AIA Persons**") to collect, use, disclose, store, retain and/or process (collectively, "**Use**") all personal data and information ("**Personal Data**") provided to AIA Persons or that they possess about me/us, in the manner and for the purposes described in the AIA Personal Data Policy ("**PD Policy**") which is available on AIA Singapore's website.

5) I/We agree to accept the provisions in the PD Policy as amended from time to time. Where Personal Data of another person is disclosed by me/us, I/we confirm that I/we have obtained the consent of the individual concerned, except to the extent such consent is not required under relevant laws to collect, use and/or disclose such Personal Data. I/We waive (on my/our own behalf and on behalf of each such other person) any right to claim against any of the AIA Persons for any Use in the nature of or for the purposes described above or in the PD Policy. I/We will indemnify AIA Persons for all losses and damages if I/we breach these provisions.

6) This consent shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not our Application/form is accepted by AIA Singapore. A photocopy of this consent shall be valid and effective as the original.

Signature of Insured Person / Claimant / Next-Of-Kin

Date (DD/MM/YY)

## Part E : To be completed by Witness

| Name of Witness | NRIC / Passport No. |
|---|---|
| Signature | Date |

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## Section 2 – Physician's Statement (to be completed by Attending Doctor at Insured's expense)

| Name of Patient | Occupation | NRIC / Passport No. |
|---|---|---|
| | | |

| **Part A : History and Circumstances Leading to Disability** | |
|---|---|
| 1. Date disability first started. (DD/MM/YY) | |
| 2. Date when the patient first consulted you for this illness. (DD/MM/YY) | |
| 3. Symptoms which the patient first related to you on the first consultation. | |
| 4. According to the patient, the duration he / she had been experiencing these symptoms. | |
| 5. Has the patient previously suffered from the illness or any related condition before? | ☐ Yes ☐ No If "Yes", please give details of consultations and the resulting diagnosis. |
| **Part B : Clinical and Physical Findings on First Consultation** | |
| 1. The symptoms or physical impairments of the patient observed by you at the first consultation. | |
| 2. The diagnosis of the patient's condition. | |
| 3. If the patient is suffering from Advanced Dementia (including Alzheimer's Disease), please complete the following questions. | |
| a) Is there evidence of deterioration or loss of intellectual capacity or abnormal behaviour resulting in significant reduction in mental and social functioning requiring the continuous supervision of the patient? | ☐ Yes ☐ No If "Yes", please specify. |
| b) Did the deterioration or loss of intellectual capacity or abnormal behaviour arise from neurosis, psychiatric illness and any drug or alchohol organic disorder? | ☐ Yes ☐ No If "Yes", please specify. |
| 4. The date when the patient was first made aware of the illness. (DD/MM/YY) | |
| **Part C : Current Health Of Patient** | |
| 1. The date when the patient last consulted you. (DD/MM/YY) | |
| 2. Please state the progress of recovery of the patient. | ☐ Recovered ☐ Improving ☐ Static ☐ Retrogressed |

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| | |
|---|---|
| 3. Current state of mobility | ☐ Ambulating without aid ☐ Ambulating without aid<br>☐ Confined to Bed ☐ Confined to Hospital ☐ Confined to wheelchair<br>Please give name of the hospital and the period of hospital confinement, if any. |
| 4. Based on your assessment on the patient, please indicate what best to describe the patient's disability status. | ☐ Good recovery – can lead a full and independent life with or without minimal neurological deficit.<br>☐ Moderately disabled – has neurological or intellectual impairment but independent.<br>☐ Severely disabled – conscious but totally dependent on others to get through daily activities.<br>☐ Vegetative survival. |
| 5. Is the patient able to return to his / her usual occupation? ☐ Yes ☐ No | |
| If "Yes", when can he / she return to work? What is the limitation? | |
| If "No", | a) Please elaborate to what extend does his / her disability prevent him / her from performing all the normal duties of his / her usual occupation? |
| | b) When can he / her return to work? What is the limitation? |
| | c) What other type of occupation can the patient perform? |
| 6. Please provide us with any other additional information that will enable the company to assess this claim. | |

7. In your opinion, does the patient fulfill the Total & Temporary Disablement definition stated below? ☐ Yes ☐ No

**Total & Temporary Disablement** shall mean disablement directly caused by Injury or Sickness and as a result of which the patient is prevented from performing every duty pertaining to the patient's occupation or employment on a regularly scheduled full-time basis and provided the patient is not otherwise gainfully employed.

8. In your opinion, does the patient fulfill the Total & Permanent Disability definition stated below? ☐ Yes ☐ No

**Total & Permanent Disability** shall mean that the disability must be total & permanent and there is neither at the point of commencement of the disability nor at any time thereafter any work, occupation or profession that the patient can ever sufficiently do or follow to earn or obtain any wages, compensation or profit for a minimum of six (6) consecutive months.

I hereby declare that I was physician in attendance during the last illness of the patient and that the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from the Company.

| | |
|---|---|
| Signature of Doctor | Date (DD/MM/YY) |
| Name / Designation | Name and Address of Clinic / Hospital & Stamp |

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## Section 3 - Activities of Daily Living (ADL)

| Name of Patient | NRIC / Passport No. |
|---|---|

**Please comment on whether the patient is able to perform the following activities of daily living :-**

| Activity | Score | | |
|---|---|---|---|
| **Feeding**<br>0 = unable<br>5 = need help cutting, spreading butter, etc., or requires soft diet<br>10 = independent | **0** | **5** | **10** |
| **Bathing**<br>0 = dependent<br>5 = independent (or in shower) | **0** | | **5** |
| **Grooming**<br>0 = needs to help with personal care<br>5 = independent (face / hair / teeth / shaving (implements provided)) | **0** | | **5** |
| **Dressing**<br>0 = dependent<br>5 = need help but can do about half unaided<br>10 = independent (including buttons, zip, laces, etc) | **0** | **5** | **10** |
| **Bowels**<br>0 = incontinent (or needs to be given enemas)<br>5 = occasional accident<br>10 = continent | **0** | **5** | **10** |
| **Bladder**<br>0 = incontinent or catheterized and unable to manage alone<br>5 = occasional accident<br>10 = continent | **0** | **5** | **10** |
| **Toilet Use**<br>0 = dependent<br>5 = needs some help, but can do something alone<br>10 = independent (on and off, dressing, wiping) | **0** | **5** | **10** |

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| Name of Patient | NRIC / Passport No. |
|---|---|
| **Activity** | **Score** |
| **Transfer (bed to chair and back)**<br>0 = unable, no sitting balance<br>5 = major help (one or two people, physical), can sit<br>10 = minor help (verbal or physical)<br>15 = independent | **0 5 10 15** |
| **Mobility (on level surfaces)**<br>0 = immobile or < 50 yards<br>5 = wheelchair independent, including corners, > 50 yards<br>10 = walks with help of one person (verbal or physical) > 50 yards<br>15 = independent (but may use any aid; for example, stick) > 50 yards | **0 5 10 15** |
| **Stairs**<br>0 = unable<br>5 = needs help (verbal, physical, carrying aid)<br>10 = independent | **0 5 10** |

| | |
|---|---|
| Signature of Doctor | Date (DD/MM/YY) |
| Name / Designation | Name and Address of Clinic / Hospital & Stamp |