Total Permanent Disability/Critical Illness/Terminal Illness Claim Form

Every question must be fully answered and the Company reserves the right to require further information should it deem necessary. Submission of this Claim Form does not guarantee admission of liability.

Name of Policyholder		Policy Number	

Section A: Personal Details of Life Insured

Full Name (as per NRIC/Passport)			
Date of Birth (dd/mm/yyyy)			
NRIC/ Passport Number			
Residential Address			
Mailing Address (If different from the above, please provide evidence)			
Nationality			
Email Address			
Contact Number	(HP)		(HOME)

Details of the Life Insured's regular doctor	Name of Doctor	Hospital/Clinic	Contact Number of Doctor

Section B: Details of Occupation/ Activities of Daily Living (ADLs)

Details of Occupation	Before Disability	After Disability (if unemployed, please indicate N.A. below)
Occupation		
Name of Employer		
Average Monthly Income ($)		
List of duties performed by the Life Insured at work		

Did the disability occur while at work?	☐ Yes	☐ No
Was any police report made? (If yes, kindly submit a copy of the police report)	☐ Yes	☐ No

Section C: Details of Illness or Disability

Please complete this section accurately by providing information of the pertaining illness or disability.

Details of Illness
1a) When were the symptoms first noticed by the Insured? (dd/mm/yyyy)

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b) Describe the nature of the symptoms? (Swelling, vomiting etc)

c) When did the Insured first consult a doctor for the symptoms? (Please provide doctor's name and clinic/hospital name)

Date of Consultation	Clinic/Hospital Name	Name of Doctor	Contact Number of Doctor

d) Is the Insured still seeking treatment? (If yes, please provide the name of doctor and hospital)

Name of Doctor	Clinic/Hospital Name	Contact Number of Doctor

e) If hospitalised, please state the period of hospitalisation:

Name of Hospital	Period of Hospitalisation	
	Date of Admission (dd/mm/yyyy)	Date of Discharge (dd/mm/yyyy)

If the illness/disability was due to an accident, please complete the following: Details of Accident

2a) What was the date, time and place of the accident?

b) Describe in detail how the accident occurred?

c) What injuries were sustained by the Insured as a result of the accident?

d) Please provide the details of the hospital and the doctor who attended to the Insured:

Date of Consultation	Clinic/Hospital Name	Name of Doctor	Contact Number of Doctor

Section D: Other Insurance

Are you insured with any other insurance company(ies) with similar benefits? ☐ Yes ☐ No

If yes, please provide the following information:

Name of insurance company	Sum Insured for the cover	Date of claim submitted for this cover

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Section E: Declaration and Authorisation

I/We 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 connection with the claim and the Policy ("Information"):

a) declare that all Information is complete, true and correct and that no information or materials have been withheld and that Etiqa Insurance Pte. Ltd. will rely and act on the Information accordingly. Otherwise, Etiqa Insurance Pte. Ltd. shall be at liberty to deny liability or recover amounts paid, whether wholly or partially;

b) acknowledge and accept that Etiqa Insurance Pte. Ltd. shall be at liberty to deny liability or recover amounts paid, whether wholly or partially, if any of the information is incomplete, untrue or incorrect in any respect or if the Policy does not provide cover on which such claim is made; and

c) acknowledge and accept that Etiqa Insurance Pte. Ltd. expressly reserves its rights to require or obtain further information as it deems necessary.

Data Protection and Consent for Use of Information

I/We give consent to Etiqa Insurance Pte. Ltd. to collect, use, disclose and/or process my/our personal data/personal information set out in this form and any other personal information provided by me/us (collectively the "Personal Information") and disclose and transfer such Personal Information to any persons and organisations, whether within or outside Singapore, including but not limited to medical sources, hospitals, doctors, other healthcare professionals, laboratories, regulator, dispute resolution centres and insurers, their associated persons/organisations, my/our or the insured person's employers or financial service providers, or their third party service providers or representatives (collectively "Third Parties") for the purpose(s) of:

a) processing, handling and/or dealing with my claims including the settlement of the claims and any necessary investigations relating to the claims;

b) carrying out and/or dealing with my instructions or responding to any enquiries by me;

c) administering my claims (including the mailing of correspondence, statements, invoices, reports or notices to me, which could involve disclosure of certain personal data about me to bring about delivery of the same as well as on the external cover of envelopes/mail packages); and/or

d) complying with applicable law in administering, processing, handling and/or dealing with my claims. (collectively the "Purposes")

US Tax Declaration & Acceptance

By ticking the appropriate box, I/We declare my tax status under United States ("US") tax law. I/We understand that a false statement or misrepresentation of tax status by a US person (for the purpose of US federal income tax) ("US Person") leads to penalties under US law.

Non-US Person
I/We represent and warrant that I/we am/are not US Person, and I/we am/are not acting for, or, a US Person. If my/our tax status changes and I/we become a US Person, I/we agree that I/we shall notify the insurance company (ies) within 30 days from the date of change.

Non-US Person with US Address (or green card holder claiming tax treaty benefits) (Form W8BEN)

US Person (US Tax ID Number: _____) (Form W9). I/We agree to indemnity Etiqa in respect of any false or misleading information regarding my/our US tax status.

_____
US citizens/residents, please sign here

Name of Claimant	:
Date	:
Witnessed by (if applicable)	:
Representative/ EIPL Staff Name	:
Representative's Code (if applicable):	
Company/Branch	:
Contact Number	:

Important Notes For Claimant

When making a claim, please take note of the following:

- The Claim Form should be completed by yourself or an authorised person.
- A copy of the Attending Physician's Statement and all Medical Reports should be submitted together with the Claim Form.
- The Attending Physician's Statement and the Medical Report is to be obtained at Claimant's own expense.
- EIPL reserves the right to require supplementary documents to be submitted for the purpose of assessing the claims submission.

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Please complete this page for further declarations:

Signature of Claimant : _____

Name of Claimant : _____

Date : _____

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Attending Physician's Medical Report

Note: I) The Insured Person/Claimant must obtain at his/her own expense the Medical Report from Attending Physician/Surgeon
II) This report must be completed by the Attending Physician/Surgeon whose replies should be as full as possible

The Insured

1. Name of Patient	
2. Admission Period	

3. Final Diagnosis (Based on ICD, 1975 Revision, WHO) of illness or extent of injury

4. What is the cause of the illness/injury?

5. Please specify the approximate date of discovery of the illness/injury:

6. How long has the illness/injury been existing prior to consulting you?

7. When did the patient first consult you for this condition?

8. Did the patient has any symptoms prior to consulting you? ☐ Yes ☐ No ☐ Not to my knowledge
If YES, please indicate the nature of symptoms and date the symptoms first started:

Doctor(s) previously consulted by the patient for the above condition:

	Name	Date	Name of Clinic / Hospital	Address
1.				
2.				

9. Describe the surgical procedures / treatment rendered. If no surgery was performed, please state the treatment / medication given.

Date of surgical procedures / treatment rendered:

10. Is the patient still under your care for this condition? ☐ Yes ☐ No
If NO, please give the date service was terminated, and furnish name and address of doctor if the patient has been referred to another doctor for follow-up:

11. What is the prognosis of this illness?

12. Is this treatment related to the following

(a) Pregnancy or Childbirth?	☐ Yes ☐ No	(f) Refractive error of the eye?	☐ Yes ☐ No
(b) Abortion or miscarriage?	☐ Yes ☐ No	(g) Dental surgery / treatment?	☐ Yes ☐ No
(c) Infertility or sub-fertility condition?	☐ Yes ☐ No	(h) Mental or nervous disorder?	☐ Yes ☐ No
(d) Sexually transmitted disease?	☐ Yes ☐ No	(i) Self Inflicted injury?	☐ Yes ☐ No
(e) Congenital anomaly; a physical defect at birth; a genetic a condition?	☐ Yes ☐ No	(j) Cosmetic Surgery?	☐ Yes ☐ No

13. (a) Is this condition related to any accident or injury? ☐ Yes ☐ No
(b) Is this a work-related illness or accident? ☐ Yes ☐ No
If YES to any of the above (a) or (b), please provide the date of the accident and explain the extent of the injury sustained.

Declaration

I hereby certify that the above patient had been examined and treated by me for the above * injuries / illness and the statement given above present my opinion of his / her condition.

Signature of Physician/Surgeon

Date

Name / Designation

Name, Address and Stamp of Clinic / Hospital

* to delete as applicable

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