* C L A I M F *

SEVERE DISABILITY 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. This form must be completed by the Assured or if he/she is unable to do so, by an immediate family member/caregiver.
4. 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.
5. Please continue to pay your premium until we have informed you the outcome of your claim.

A. Details of Policy

Policy Number(s)

B. Details of Life Assured and Assured

Details of Life Assured

Name of Life Assured		NRIC / FIN / Passport Number	
Date of Birth (dd/mm/yyyy)	Gender	Marital Status	❒ Single ❒ Married ❒ Divorced
Nationality		Ethnic Group	❒ Chinese ❒ Indian ❒ Malay ❒ Others
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 in to https://mysinglife.singlife.com/account/login to update your contact details if there are any changes.

C. Details of Caregiver

Full Name (as shown in NRIC)	NRIC / FIN / Passport / UEN Number	
Relationship to Life Assured	Date of Birth (dd/mm/yyyy)	Gender
Address		
Email	Contact Number	

D. Mode of Payment

For a better payment experience, payments to the Payee will be credited to the bank account linked to the Payee's PayNow-NRIC/FIN. Please ensure that you have registered for PayNow using your NRIC/FIN.

Note: For payment to third-party payee or Homes/Institutions, please complete the **Letter of Undertaking & Indemnity** section.

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Name of Payee	NRIC / FIN Number of Payee

E. Details of Child Aged 21 and Below (applicable to Dependent Care Benefits only)

Full Name of Youngest Child	Date of Birth (dd/mm/yyyy)	Place of Birth	Gender ❒ Male ❒ Female

Birth Certificate Number (Please provide a copy of the child's **birth certificate**)	If the child is legally adopted, please state **Date of Adoption** and provide a copy of legal adoption papers (dd/mm/yyyy)

F. Details of Illness / Disability

1. Details of the conditions that the Life Assured is suffering and claiming

Exact Diagnosis	Date of Diagnosis (dd/mm/yyyy)	**First** Symptoms Presented	Date of **First** Symptoms (dd/mm/yyyy)	Name and Address of Doctor **First** Consulted for the Symptoms	Date of **First** Consultation (dd/mm/yyyy)

2. Has the Life Assured ever been admitted to hospital in the **last 5 years**? ❒ Yes ❒ No
If "Yes", please provide details of the conditions below:

Name(s) and Address(es) of Doctor(s)	Reason(s) for Admission	Diagnosis	Date of **First** Onset of Condition

3. Please provide the details of all family / regular / company doctor(s) consulted for minor ailments (e.g. 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

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4. Name and address of doctor(s) consulted in the **last 5 years**

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

5. If disability is due to accident, please provide date of accident and attach a copy of accident report.

   Date of Accident (dd/mm/yyyy):

   If no report is available, please describe:
   (a) the nature of the accident

   (b) extent of injuries sustained.

6. 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):

7. Was the Life Assured performing **any** work or engaged in an occupation/profession **at the time of condition**? ❒ Yes ❒ No

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

9. 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)

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G. Declaration and Authorisation

Note: If the Assured has been assessed by a doctor to lack mental capacity*, the Assured's appointed Donee(s)/Deputy(s), or Caregiver 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).

1. I/We hereby declare that the above statements are true and complete, and I/We have not withheld any material fact from Singapore Life Ltd.
2. I/We declare that I am/We are not an undischarged bankrupt or insolvent or has/have executed any deed or transfer for the benefit of creditors within the last twelve (12) months.
3. I/We agree that:
   a. this declaration shall form part of my/our application for Singlife ElderShield Standard, Singlife ElderShield Plus, Singlife CareShield Standard and Singlife CareShield Plus Benefits ("LTC Benefits").
   b. this claim signifies my/our consent to the Insurer to obtain medical information from any doctor whom I/We have consulted and I/We authorise the doctor to release such information to the Insurer.
   c. the Insurer may release any relevant information concerning me/us (including my/our medical information) to any third party, which the Insurer deems necessary.
   d. any third party has received any information concerning me/us 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 me/us (including my medical information) to any other party for any purposes related to my/our application or claim for my/our LTC Benefits.
   e. a photocopied copy of this form shall be treated as valid and binding as if it were the original.
4. I/We consent to Singapore Life Ltd. ("Singlife") (and Singlife related group of companies) collecting, using and/or disclosing my/our personal data (whether contained in this form or obtained from other sources; existing data in Singlife's record or to be collected in future) for the following purposes:
   a. to issue and administer my/our existing and/or new policy(ies) and/or account(s) with Singlife and such other purposes ancillary or related to the administering of the policy(ies) and/or account(s), including the processing of my/our personal data for underwriting purposes, payment of premiums (including, where applicable, the deduction of premiums due from the Medisave accounts of the Lives Assured) and/or claims purposes;
   b. for statistical, research, compliance, audit and regulatory purposes; and
   c. to provide general information on product enhancements and services relevant to my/our needs or policies (including increasing benefits, adding riders/supplements and/or Lives Assured) as well as to provide financial advice and product recommendations to me/us, where applicable.
5. I/We consent to Singlife (and Singlife related group of companies) disclosing and transferring my/our personal data to (i) Singlife (and Singlife related group of companies) and their respective third party service providers, reinsurers, suppliers and intermediaries; (ii) the Government of Singapore; (iii) statutory boards; and (iv) organisations approved by the Government of Singapore, whether located in Singapore or elsewhere, for the above purpose and such other purposes as described in Singlife's Personal Data Protection Statement ("Statement").
6. I/We have read and understood the Statement and Singlife's Data Protection Notice which may be found at www.singlife.com/pdpa. The Statement and Singlife's Data Protection Notice may be updated from time to time without notice. I am/We are aware that I/We should visit your website regularly to ensure that I am/We are well informed of the updates.

Note: If you are completing 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 who you have disclosed.

Name of Assured	NRIC / FIN / Passport Number	Signature / Thumb Print of Assured	Date (dd/mm/yyyy)

To be completed if form is filled up by family members/caregiver	
Name of Family Member / Caregiver*	Signature of Family Member / Caregiver*
Contact Number	Email
Relationship to Assured	Date (dd/mm/yyyy)

* Please delete accordingly

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Important Note:
1. This Letter of Undertaking and Indemnity is a legal document. Please seek legal advice if you have any enquiries. Your completion of this Form will facilitate the prompt processing of your claim.
2. Please complete this Form if payment is to be made to a Third-Party Payee.

LETTER OF UNDERTAKING AND INDEMNITY

(To be completed by Third-Party Payee)

TO: SINGAPORE LIFE LTD. - Individual Life Claims Department

PART I: UNDERTAKING & INDEMNITY AUTHORISATION

I/We declare that I am/We are the main caregiver of the Assured, _____

(Name of Assured) of NRIC / FIN Number _____ Policy No(s). _____.

In consideration of Singapore Life Ltd. ("the Company") agreeing or having agreed, at the Assured's/my/our request to pay the benefits, which the Assured is entitled to under the Singlife ElderShield Standard/Singlife ElderShield Plus/Singlife CareShield Standard/Singlife CareShield Plus Policy ("LTC Policy"), to me/us, I/We agree and undertake as follows:

1. That I/We must first apply the LTC Policy benefits paid by the Company for the care of the Assured.
2. That I/We will inform the Company immediately upon becoming aware that the Assured recovers from the disability, which refers to the inability to perform at least 3 Activities of Daily Living or passes away.
3. That I/We will repay any LTC Policy benefits, which the Assured is not entitled or ceases to be entitled to, upon written demand by the Company. I/We agree and undertake that if I/We fail to make such repayment, I/We will fully indemnify the Company against any loss, damage, cost and expenses whatsoever, including any legal cost, which may be incurred by the Company as a result of my/our failing to fully repay the LTC Policy benefits or of the Company's need to enforce its rights under the Undertaking or Indemnity.
4. I/We consent to Singapore Life Ltd. ("Singlife") (and Singlife related group of companies) collecting, using and/or disclosing my/our personal data (whether contained in this form or obtained from other sources; existing data in Singlife's record or to be collected in future) for the following purposes:
   a. to issue and administer my/our existing and/or new policy(ies) and/or account(s) with Singlife and such other purposes ancillary or related to the administering of the policy(ies) and/or account(s), including the processing of my/our personal data for underwriting purposes, payment of premiums (including, where applicable, the deduction of premiums due from the Medisave accounts of the Lives Assured) and/or claims purposes;
   b. for statistical, research, compliance, audit, and regulatory purposes; and
   c. to provide general information on product enhancements and services relevant to my/our needs or policies (including increasing benefits, adding riders/supplements and/or Lives Assured) as well as to provide financial advice and product recommendations to me/us, where applicable.
5. I/We consent to Singlife (and Singlife related group of companies) disclosing and transferring my/our personal data to (i) Singlife (and Singlife related group of companies) and their respective third-party service providers, reinsurers, suppliers and intermediaries; (ii) the Government of Singapore; (iii) statutory boards; and (iv) organisations approved by the Government of Singapore, whether located in Singapore or elsewhere, for the above purpose and such other purposes as described in Singlife's Personal Data Protection Statement ("Statement").
6. I/We have read and understood the Statement and Singlife's Data Protection Notice which may be found at www.singlife.com/pdpa. The Statement and Singlife's Data Protection Notice may be updated from time to time without notice. I am/We are aware that I/We should visit your website regularly to ensure that I am/We are well informed of the updates.

Note: If you are completing 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.

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PART II: PAYMENT AUTHORISATION

I/We hereby authorise the Company to credit the Singlife ElderShield Standard/Singlife ElderShield Plus/Singlife CareShield Standard/Singlife CareShield Plus benefits that are payable to the Assured under the LTC Policy into my/our account.

Details of Payee (aged above 21 years)

Full Name of Payee	NRIC / FIN / Passport Number Number	Contact Number
Address		
Signature of Payee	Relationship to Assured	Date (dd/mm/yyyy)

For Homes / Institutions only (if benefits are to be made to the Home/Institution)

Name of Bank Account Holder(s)	Name of Bank	Bank Account Number[1]
Name of Home / Institution		Address of Home / Institution
Name of Authorised Officer	Contact No. of Authorised Officer	Home / Institution's Official Stamp
Signature of Authorised Officer	Date (dd/mm/yyyy)	
Full Name of Assured	Signature / Thumbprint of Assured	Date (dd/mm/yyyy)

[1] Homes or Institutions that wish to receive policy benefits and/or claims proceeds via Electronic Fund Transfer will need to 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.

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