

SEVERE DISABILITY CLAIM FORM

For ElderShield and CareShield Life Supplement Plans

Dear Assured (Policyholder),

We are sorry to learn of your disability.

For us to process your claim, please:

1. Complete the attached Severe Disability Claim Form as best as you can. If you are unable to do so, please have it completed by your immediate family member or caregiver.
2. Call the clinic to make an appointment for the disability assessment. Please refer to the list of appointed assessors at www.singlife.com.
3. Bring along the following for the appointment:
 - Severe Disability Claim Form to be completed by Assured (Policyholder)/Caregiver
 - Letter of Undertaking and Indemnity to be completed (applicable for Third Party Payee or Homes/Institutions only)
 - Detailed Inpatient Discharge Summary and any relevant hospital reports that are available. Please note that this is required for the assessor to proceed with the assessment.
 - Medicine (if any)
4. The fee for the assessment is to be paid by you, unless waived as part of the first-time assessment fee waiver for CareShield Life. Please note that this is required for the assessor to proceed with the assessment. You will be fully reimbursed if you meet the severe disability criteria.
5. Please submit the following documents to us:
 - a) Severe Disability Claim Form to be completed by Assured (Policyholder)/Caregiver
 - b) Letter of Undertaking and Indemnity to be completed (applicable for Third Party Payee or Homes/Institutions only)
 - c) Copy of all diagnostic reports, including resting ECGs, exercise stress test, troponin results, enzymes assays, isotope studies imaging coronary angiography, blood tests, ultrasound, biopsy, histopathology report, CT scans, other imaging studies, laboratory tests results, detailed Inpatient Discharge Summary and any relevant hospital reports that are available.
 - d) Copy of Identity Card or Passport of the Life Assured/Insured Person
 - e) Copy of Identity Card or Passport of the Caregiver
 - f) Copy of Identity Card or Passport of the Payee
 - g) Copy of Birth Certificate/Legal adoption paper of the child (applicable for Dependant Care Benefit only)
 - h) Copy of bank passbook/statement or e-statement with full name and account number clearly indicated on the same page. All other information may be blanked out (applicable for Homes/Institutions only) *

Once we have received all the required documents/information, we will process your claim and inform you of the outcome as soon as possible.

Submission of documents:

All claim documents can be submitted through the Financial Adviser Representative or intermediaries or by Post to:

4 Shenton Way
#01-01 SGX Centre 2
Singapore 068807
Attn: Individual Life Claims

If you need help, please contact our staff at **6827 9933** or email us at cs_life@singlife.com.

***Note:** 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 or e-statement with full name and account number clearly indicated on the same page. All other information may be blanked out.



SEVERE DISABILITY CLAIM FORM

To be completed by the Assured (Policyholder) or if he/she is unable to do so, by an immediate family member/caregiver.

Important: Please read the instructions stated on the cover page before completing this form.

POLICY NUMBER(S): _____				
A. Personal Particulars				
1. Details of Life Assured				
Full Name (as shown in NRIC)		NRIC / FIN / Passport / Birth Certificate No.		
Date of Birth (ddmmyyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		
Nationality	Ethnic Group <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Malay <input type="checkbox"/> Others			
Residential Address *	Home Contact No.			
Email	Mobile No.			
Name and address of employer	Occupation			
* Note: All correspondence will be sent to the mailing address as per our existing record.				
2. Details of Caregiver				
Full Name (as shown in NRIC)		NRIC / FIN / Passport/ UEN No.		
Relationship to Life Assured	Date of Birth (ddmmyyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
Address	Mobile			
Email	Other Contact No.			
3. 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 check that you have registered for PayNow with your bank, using your NRIC/FIN. Note: For payment to third party payee or Homes/Institutions, please complete the Letter of Undertaking & Indemnity .				
Name of Payee		NRIC / FIN No. of Payee		
4. Details of child aged 21 and below (Applicable to Dependent Care Benefits only)				
Full Name of Youngest Child		Date of Birth (ddmmyyyy)	Place of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Birth Certificate Number (please provide copy of birth certificate of child)		If the child is legally adopted, please state Date of Adoption (please provide copy of legal adoption papers) (ddmmyyyy)		

B. Details of Claim and Medical History

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

Exact diagnosis	Date of diagnosis (ddmmyyyy)	First symptoms presented	Date of First symptoms (ddmmyyyy)	Name and Address of doctor First consulted for the symptoms	Date of First consultation (ddmmyyyy)

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 and address of Doctor(s)	Reason for Admission	Diagnosis	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 conditions:

Name and address of Doctor(s)	First Consultation (ddmmyyyy)	Last Consultation (ddmmyyyy)	Reason(s) for consultation	Treatment Provided

4. Name and address of doctors consulted in the last 5 years.

Name and address of Doctor(s)	First Consultation (ddmmyyyy)	Last Consultation (ddmmyyyy)	Reason for Consultation

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

Date of Accident (ddmmyyyy):

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 date returned to work (ddmmyyyy):

No – Please state the expected date to return to work (ddmmyyyy):

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

8. Date where the condition had totally and permanently prevented Life Assured from performing the occupation (ddmmyyyy):

9. Is the Life Assured claiming from any other Insurance Company(ies) or other sources ie Employer, Work Injury Compensation Act (WICA) and etc in respect of this illness/disability? Yes No

If “Yes”, please provide the details:

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

C. Activities of Daily Living

C. Activities of Daily Living		Disability Start Date (ddmmyyyy)
Please tick (✓) against the box that most accurately describe the Life Assured's ability.		
<p>1. Washing The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.</p> <p><input type="checkbox"/> No help is needed.</p> <p><input type="checkbox"/> Some help / supervision is needed (e.g. to wash the back, to wash hair).</p> <p><input type="checkbox"/> Needs someone to help most of the time.</p> <p><input type="checkbox"/> Not able to do at all (needs to be washed or bathed entirely by caregiver).</p>		
<p>2. Dressing The ability to put on, take off, secure, and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical or medical appliances.</p> <p><input type="checkbox"/> No help is needed.</p> <p><input type="checkbox"/> Some help / supervision is needed (e.g. to button clothes, to put on trousers).</p> <p><input type="checkbox"/> Needs someone to help most of the time.</p> <p><input type="checkbox"/> Not able to do at all (needs to be dressed entirely by caregiver).</p>		
<p>3. Feeding The ability to feed oneself food after it has been prepared and made available.</p> <p><input type="checkbox"/> No help is needed.</p> <p><input type="checkbox"/> Some help / supervision is needed (e.g. to scoop food, to put food in mouth).</p> <p><input type="checkbox"/> Needs someone to help most of the time.</p> <p><input type="checkbox"/> Not able to do at all (needs caregiver to feed entirely or is tube-fed).</p>		
<p>4. Toileting The ability to use the lavatory or manage bowel and bladder function through the use of protective undergarments or surgical appliances if appropriate.</p> <p><input type="checkbox"/> No help is needed.</p> <p><input type="checkbox"/> Some help / supervision is needed (e.g. to get on or off the toilet).</p> <p><input type="checkbox"/> Needs someone to help most of the time.</p> <p><input type="checkbox"/> Not able to do at all (needs caregiver to manage diapers and/or catheter).</p>		
<p>5. Mobility / Walking or Moving Around The ability to move indoors from room to room on level surfaces.</p> <p><input type="checkbox"/> No help is needed.</p> <p><input type="checkbox"/> Some help / supervision is needed (e.g. to be supervised by someone closely in case of fall).</p> <p><input type="checkbox"/> Needs someone to help most of the time.</p> <p><input type="checkbox"/> Not able to do at all (needs to be carried).</p>		
<p>6. Transferring The ability to move from a bed to an upright chair or wheelchair, and vice versa.</p> <p><input type="checkbox"/> No help is needed.</p> <p><input type="checkbox"/> Some help / supervision is needed (e.g. to be lifted from lying position to sitting position from bed).</p> <p><input type="checkbox"/> Needs someone to help most of the time.</p> <p><input type="checkbox"/> Not able to do at all (needs to be carried).</p>		

D. Declaration and Authorisation

Note: If the policyholder has previously been assessed by a doctor to lack mental capacity*, the policyholder'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/affix thumbprint. The mentally incapacitated policyholder need not sign off/affix thumbprint.

*A separate doctor's memo should be submitted to indicate that the policyholder 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/We am/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/We am/are aware that I/we should visit your website regularly to ensure that I/we am/are well informed of the updates.

Note: 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 who you have disclosed.

 Name of Policyholder NRIC/Passport No. Signature/Thumb Print of Policyholder Date (ddmmyyyy)

To be completed if form is filled up by family members / caregiver	
Name of family member / caregiver*	Signature of family member / caregiver*
Contact No.	Email
Relationship to Policyholder	Date (ddmmyyyy)

* Please delete accordingly

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 Policyholder, _____
_____ (Name of Policyholder) of NRIC No. _____
Policy No(s). _____.

In consideration of Singapore Life Ltd. ("the Company") agreeing or having agreed, at the Policyholder's/my/our request to pay the benefits, which the Policyholder 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 Policyholder.
2. That I/we will inform the Company immediately upon becoming aware that the Policyholder 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 Policyholder 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/We am/are aware that I/we should visit your website regularly to ensure that I/we am/are well informed of the updates.

Note: 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 who you have disclosed.

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 Policyholder under the LTC Policy into my/our account.

Details of Payee (age above 21 years old)		
Full Name of Payee	NRIC No.	Contact No.
Address		
Signature of Payee	Relationship to Policyholder	Date (ddmmyyyy)

For Homes or Institutions only (if benefits are to be made to the Home or Institution)		
Name of Bank Account Holder(s)	Name of Bank	Bank Account Number ¹
Name of Home or Institution		Address of Home or Institution
Name of authorised officer	Contact No. of authorised officer	Home/Institution official stamp
Signature of authorised officer	Date (ddmmyyyy)	
Full Name of Policyholder	Signature/thumbprint of Policyholder	Date (ddmmyyyy)

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 or e-statement with full name and account number** clearly indicated on the same page. All other information may be blanked out.