AVIVA LTD
Group Life & Health Claims
4 Shenton Way, #01-01 SGX Centre 2
Singapore 068807
Tel: 6827 8030 Fax: (65) 6827 7705
Company Registration No. 196900499K

MINDEF & MHA GROUP INSURANCE – CLAIMS PROCEDURE AT A GLANCE

Please refer to the following documents required for filing each type of claim:

A. For Death Claim under Group Term Life and Group Personal Accident policy:

1) Death Claim Form (to be completed)
2) Certified True Copy of Death Certificate
3) Certified True Copy of Marriage Certificate if deceased was married
4) Certified True Copy of deceased's Birth Certificate and copy of deceased's parents' identity cards if deceased was not married
5) Certified True Copy of claimant's identity card (front and back)
6) Certified True Copy of Last Intestate Will (if any)

Note: Aviva will request for the Physician Statement if there is insufficient information on the submitted documents.

If death cause is due to accidental events, please submit:

1) Police Investigation Report
2) Post Mortem / Autopsy Report including Toxicology Report
3) Coroner's Inquest / Verdict

B. For other / additional benefits claim under Group Personal Accident policy, please submit:

Disappearance

1) Newspaper Clippings (if any)
2) Certified True Copy of Airline / Authorities letter confirming that deceased was a passenger of the unfortunate accident
3) Certified True Copy of Immigration & Checkpoints Authority (ICA) letter indicating updated life status of deceased

Child Education Fund Benefit

1) Certified True Copy of child's Birth Certificate (front and back)
2) Certified True Copy of child's Concession Pass (front and back) or Enrolment letter from Institution

Compassionate Death Allowance Benefit

1) Certified True Copy of funeral expenses invoices

C. For Total & Permanent Disablement / Total & Permanent Dismemberment due to Accident / Advance Payment Benefit / Injury due to Accident / Disability Income / Comatose Lump Sum Benefit Claim under Group Term Life and Group Personal Accident policy:

1) Claim Form (to be completed)
2) Physician Statement (to be completed by attending physician)
3) Certified True Copy of all related diagnostic reports, e.g. CT Scans, MRI Scans, X-Rays, laboratory reports
4) Certified True Copy of Insured Person's NRIC (front and back)
5) Certified True Copy of Insured Member's / Insured Affiliate Member's NRIC (front and back), if Insured Person is a dependant

Additional documents required for Disability Income Benefit Claim:

1) Employment and/or Income documents, e.g. confirmation from employer on absence from work, termination letter, pay slips, IR8A Form, CPF Statements, Commission Statement, etc.
2) Copies of all medical leave certificates

D. For other / additional benefits claim under Group Personal Accident policy, please submit:

Mobility aid upon accidental Total & Permanent Disablement

1) Certified True Copy of mobility aids purchase and installation invoices

Ambulance Cost

1) Certified True Copy of ambulance fee invoice (transportation to hospital)

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Home Rehabilitation Renovation Expenses

1) Certified True Copy of installation invoices

Note: Cost of the Physician's Statement and/or medical evidence shall be borne by the Insured Person / Insured Member / Insured Affiliate Member.

E. For Living Care / Living Care Plus Claim

1) Living Care / Living Care Plus Claim Form (to be completed)
2) Physician Statement (to be completed by attending physician)
3) Certified True Copy of all related diagnostic reports, e.g. CT Scans, MRI Scans, PET Scans, X-Ray, histopathology / laboratory reports
4) Certified True Copy of Insured Person's NRIC (front and back)
5) Certified True Copy of Insured Member's / Affiliate Member's NRIC (front and back), if Insured Person is a dependant

Note: Cost of the Physician's Statement and/or medical evidence shall be borne by the Insured Person / Insured Member / Insured Affiliate Member.

F. For Daily Hospital Cash Benefit / Hospital Recuperation Benefit / Simple Fracture or Other Fracture due to Accident Claim under Group Term Life and Group Personal Accident policy:

1. Claim Form (to be completed)
2. Copy of finalized hospital bill (admission and discharge dates have to be indicated)
3. Copy of Inpatient Discharge Summary / Doctor's memorandum indicating diagnosis and date of injury
4. Copy of Insured Person's NRIC (front and back)
5. Copy of Insured Member's / Insured Affiliate Member's NRIC (front and back), if Insured Person is a dependant

IMPORTANT NOTE:

- **The above are the basic documents required for filing the claim, any other additional documents required will depend on the case itself. We reserve the right to pursue for the said documents.**
- **For submission via email, please ensure that documents are colored scanned.**

Submission of claim documents:

To submit a claim, complete the relevant Claim Form and also have on-hand the required supporting documents. Thereafter, email us the complete set of claim documents for our claim review. We will acknowledge your electronic claim submission within 2 business days.

Alternatively, you may call us and we will be able to guide you through the claim process.

You may contact us at:

MINDEF & MHA Claims Hotline – 6827 7991

Our Operating Hours:
Mondays – Fridays 9am – 6pm
Closed on Saturdays, Sundays and Public Holidays

Email Addresses – MINDEF_Claims@aviva-asia.com (For Mindef Claims)

MHA_Claims@aviva-asia.com (For MHA Claims)

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MINDEF & MHA GROUP INSURANCE
GROUP LIVING CARE / LIVING CARE PLUS CLAIM FORM

IMPORTANT:

1. Please refer to the **Claims Procedure at a Glance** for documents required for submission of this claim.
2. The Insured Person/Insured Member/Insured Affiliate Member 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 Insured Person/Insured Member/Insured Affiliate Member shall bear the cost of medical reports fees (if any).
4. Please continue to pay the premium until we have informed you on the outcome of your claim.
5. Aviva Ltd does not admit liability by the mere issue of this or any other form.

SECTION 1 – To be completed by the Insured Person

Type of Claim (please √ box)	❒ Living Care	❒ Living Care Plus		
A. Details of Insured Person				
Name of Insured Person				
ID/FIN/Passport/BC No	Date of Birth	Marital Status	Gender	Religion
Mailing Address			Contact No.	
Email				
Name of Insured Member/Insured Affiliate Member (if different from Insured Person)	Insured Member/Insured Affiliate Member ID/FIN/Passport/BC No			
B. Details of Illness				
1) Date symptom 1st started	2) Describe symptoms 1st presented			
3) Date 1st consulted doctor for the condition				
4) Name & Address of doctor 1st consulted				
5) Date of diagnosis	6) Exact diagnosis			
7) What was the treatment (including any surgery) recommended and received by you?				
8) Have you previously suffered from or received treatment for a similar or related Illness? ❒ Yes ❒ No If "Yes", please provide full details.				

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B. Details of Illness (continue)

9) Is the Illness a result of an Accident? ❒ Yes ❒ No If "Yes", please state

Date & Time of Accident	Place of Accident

Describe in detail how the accident happened

Nature and extent of injuries

Was the accident reported to the Police? ❒ Yes ❒ No If "Yes", please provide a copy of the police report.

10) Details of doctor(s) consulted or hospital(s) admitted for this Illness

Name & Address of Doctor	Date 1st & Last Consulted	Treatment Provided

11) Details of doctor(s) consulted for any other disorders / conditions

Name & Address of Doctor	Reason for Consultation	Treatment Provided	Date 1st & Last Consulted

12) Have Insured Person been hospitalized for condition(s) related to your Illness? ❒ Yes ❒ No If "Yes", please state

Name of Hospital	Date of Admission	Date of Discharge	Reason for Hospitalization

13) Is Insured Person claiming from any other Insurer(s) or other sources in respect of this Illness? ❒ Yes ❒ No
If "Yes", please provide the details.

Name of Insurer	Type of Plan	Policy Effective Date	Sum Assured

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C. DECLARATION AND AUTHORISATION

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 has been withheld nor any relevant circumstances omitted.

I/We declared that I/We am/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 further consent to Aviva Ltd seeking information from any clinic, hospital, physician, person, organization, employer that may be required in connection with this claim and I/We authorize the giving of such information to Aviva. A photocopy of this authorization shall be considered as effective and valid as the original.

I/We consent to Aviva (and Aviva 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 Aviva.

I/We also consent to Aviva (and Aviva related group of companies) transferring my/our personal data to Aviva related group of companies and/or third party service providers, reinsurers, suppliers or intermediaries whether located in Singapore or elsewhere, for the above purposes.

For full details of the purposes of collection, use and disclosure of your personal data, please visit http://www.aviva.com.sg/pdpa.html.

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.

Signature of Insured Member /Insured Affiliate Member:.....	Signature of Insured Person:.....
Name of Insured Member /Insured Affiliate Member:.....	Name of Insured Person:.....
NRIC/FIN No:.....	NRIC/FIN No:.....
Address:.....	Address:.....
.....	.....
Contact No:.....	Contact No:.....
Email:.....	Email:.....
Date:.....	Date:.....