Disability and/or terminal illness claim – claimant's statement

Important
We're sorry to receive notice of the life assured's condition. In order for us to process your claim, please complete this claim form in full and submit the following documents.

Documents required

1. This disability and/or terminal illness claim form (to be completed by claimant)
2. Consent form
3. Copies 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
4. Reports that are available
5. Copy of the NRIC/FIN/passport of the life assured
6. Copy of the NRIC/FIN/passport of the claimant, if different from the life assured
   any other documents that support the claim (e.g. official certificate of appointment of the legal guardian of life assured who is a minor)

Proof of life assured's relationship with claimant as follows (where applicable)

Relationship to life assured	Documents required
Spouse	Marriage certificate of life assured
Children	Birth certificate of life assured's child
Parent	Birth certificate of life assured and claimant
Sibling	Birth certificate of life assured and claimant

Important notes

1. All documents that are not issued in Singapore must be authenticated by either i) the Singapore embassy in the country of death, ii) Singapore Consulate or iii) Notary Public.

2. These said documents shall be in the forms as prescribed and shall be furnished at the expense of the claimant(s).

3. All documents submitted must be in English. Any document that is not in English must be accompanied by an English translated copy of the document made by a certified translator/interpreter.

4. All questions in this claim form must be fully and truthfully answered. The Company reserves the right to require or obtain further information, if deemed necessary.

5. The acceptance of this form is not an admisson of liability on the part of FWD.

6. Please note that, under the policy terms and conditions, the policy may be void if any information provided in this claim form are made knowingly by you that it is materially false or misleading.

7. The Company reserves the rights to request for additional documents when deemed necessary.

8. Please continue paying your premiums to keep your cover active.

9. A waiting period of 6 months from the date of disability must elapse before a disability claim will be considered.

Policy number

Details of life assured

Name of life assured

NRIC/FIN/Passport

Marital status

Address

Contact no

Email

Occupation

Name and address of employer

Details of disability/illness

Date of first consultation with a doctor for the condition
(dd/mm/yyyy)

Name of doctor and address of hospital/clinic

Describe symptoms presented

Date symptoms first started
(dd/mm/yyyy)

Details of diagnosis

Date of first diagnosis
(dd/mm/yyyy)

Has the life assured previously sufferred from, or received treatment for a similar or related disability/illness? If "yes", please provide details

How long did the life assured experience symptoms for before consulting a doctor?

If the disability suffered is due to an accident, please provide

Date & time of the accident

Place of accident

Please describe how the accident occurred

Please describe the nature and extent of injuries sustained

Was the accident reported to the police?
If "yes", please provide the name of police station at which the accident was reported, name of the police officer in charge, and enclose a copy of the police report

Was there any eyewitness to the accident?
If "yes", please provide the name and address of witness

If the life assured is confined/hospitalised

Is the life assured currently confined to bed/house/ hospital/other?

If the life assured is not confined/hospitalised, please describe briefly his/her daily activities

Date the life assured returned to work (dd/mm/yyyy)

Date the life assured is **expected** to return to work (dd/mm/yyyy)

Details of doctor consultation and/or hospital admission for **this** disability/illness

Name of doctor

Address

Date of first consultation

Date of last consultation

Treatment provided

Details of doctor consultation and/or hospital admission for conditions related to this disability/illness

Name of doctor

Address	
Date of admission	
Date of discharge	
Reason for hospitalisation	
Treatment provided	

Details of doctor consultation and/or hospital admission for any other disorders/illnesses.

Name of doctor	
Address	
Date of first consultation	
Date of last consultation	
Reason(s) for consultation	
Treatment provided	

Details of regular doctor

Name of doctor	

Address

Details of life assured's occupation (just before the disability/illness)

Occupation (title and job duties)

Name & address of employer

Employment status

- ☐ full time
- ☐ part time
- ☐ unemployed
- ☐ contract
- ☐ temporary

Others: _____

Date this disability has totally and permanently prevented the life assured from performing the material duties of his/her occupation (dd/mm/yyyy)

List of duties preventing the life assured from performing his/her duties totally and permanently due to this disability

Date the life assured last worked (dd/mm/yyyy)

Other insurance

Does the Life Assured have any other insurance policy?

Name of insurance company/type of plan/date of issue/sum assured

Are there any claims submitted or to be submitted to any other insurance company in respect of this illness/disability?

Other information

Has the life assured been bankrupt or insolvent or executed any deed or transfer for the benefit of creditors since becoming interested in the policy?

Please provide detail of life assured's regular doctor(s)

Hospital/clinic name

Hospital/clinic name

Date of consultation

Reason(s) for consultation

Mode of payment

Once approved, your claim amount will be credited into your bank account. Kindly provide your bank account details.

☐ **Bank transfer** ☐ **Cheque**

Name of bank

Account holder's name

Account number

If you prefer to receive a cheque, kindly let us know.
Cheque (to be sent to the official address stated in the policy)

Declaration, authorisation and consent to use personal data

1. I certify that the information provided in this form is true and complete and I have not withheld any material information that could affect this claim.

2. For the purposes of policy administration, which includes the processing and/or investigation of this claim, I hereby:

   a. authorise any person or organisation who has relevant information on this claim, including but not limited to any medical practitioner, health care provider, clinic, hospital, insurance company and/or investigative agency, to release and exchange any and all information (including personal health information) requested by FWD Singapore Pte. Ltd. and/or its claims service providers;

   b. authorise FWD Singapore Pte. Ltd. and/or its claim service providers to collect, use, disclose and/or exchange with such persons or organisations referred to in (a) above any and all relevant information (including personal health information); and

   c. confirm that I am authorised to disclose information (including personal health information) about the insured person if this claim is made on his/her behalf.

3. I also give consent for FWD Singapore Pte. Ltd. to collect, use or disclose my personal data for audit, business analysis, reinsurance purposes and for the purposes set out in FWD's Privacy Policy, which can be found at www.fwd.com.sg.

4. I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

5. My signature below will signify my consent.

Signature of life assured/claimant

Signed and declared in Singapore on
(dd/mm/yyyy)

Name of life assured/claimant

Relationship with life assured

Contact number

Email

Consent form

1. To

2. Address

3. Name of Insured

4. NRIC/FIN

Declaration & authorisation

1. For the purposes of policy administration, which includes the processing and/or investigation of this claim, I hereby:
   a. authorise any person or organisation who has relevant information on the above Insured and/or this claim, including but not limited to any medical practitioner, health care provider, clinic, hospital, insurance company and/or investigative agency, to release and exchange any and all information (including personal health information) requested by FWD Singapore and/or its claims service providers;
   b. authorise FWD Singapore and/or its claim service providers to collect, use, disclose and/or exchange with such persons or organisations referred to in (a) above any and all relevant information (including personal health information) and
   c. confirm that I am authorised to disclose information (including personal health information) about the Insured person(s) if this claim is made on his/her/their behalf.
2. I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.
3. My signature below will signify this consent.

Signature of insured/next-of-kin of deceased insured/insured's parent or legal guardian (if Insured is below 21 years of age)

Name of signatory

Relationship with life assured

NRIC/FIN/Passport

Date