DISABILITY CLAIM FORM

中国人寿保险(新加坡)有限公司
China Life Insurance (Singapore) Pte. Ltd.

Dear Claimant

We are sorry to learn of the Life Insured's Condition.

In order for us to process the claim, please provide the following:

1. Claimant's Statement (Section A of the Disability Claim Form)
2. Medical Specialist Report (Section B of the Disability Claim Form)
3. Copies of all diagnostic reports (e:g Histopathology report, MRI report, Troponin test results) detailed Inpatient Discharge Summary and any relevant hospital reports that are available
4. Copy of Claimant's NRIC or Passport
5. Copy of the NRIC/FIN or Passport of the Policy Owner, if different from Life Assured

Important Notes

1. Please note that, under the policy terms and condition, 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.
2. The acceptance of this form is not an admission of liability by China Life Insurance (Singapore) Pte. Ltd. ("CLIS", "our", "us", "we").
3. All documents submitted must be in English. Any document which is in foreign language must be translated to English by a certified translator.
4. Any expense that is incurred in obtaining any of the documents required, including but not limited to the Specialist Report or medical evidences, for claim filing shall be borne by you.
5. Please submit all required documents and we will assess the claim upon receipt of all the required documents and advise whether medical reports or further documentary evidences are required.
6. The Company may communicate with you with regard to this claim by email and/or letter by post.

Submission of Documents

You may submit the claim documents personally at our Customer Care Centre, through your financial adviser representative or by post to:

Claims Department
China Life Insurance (Singapore) Pte. Ltd.
1 Raffles Place #46-00 One Raffles Place Tower 1
Singapore 048616

If you have any queries, please call us at Customer Care Hotline at (65) 6727 4800 or email us at Customercare@chinalife.com.sg.

SECTION A – CLAIMANT'S STATEMENT

(to the completed by the Life Insured who is at least 18 years old or Policy Owner if the Life Insured is below 18 years old)

1) POLICY NUMBER(S)

2) INFORMATION OF LIFE INSURED

Full Name (as shown in NRIC/ Passport)	
NRIC / FIN / Passport Number	
Date of Birth (dd/mm/yyyy)	
Gender	☐ Female ☐ Male
Marital Status	
Mailing Address	
Contact Number	
Email Address	
Occupation	
Name and Address of Employer	

3) DETAILS OF OCCUPATION / ACTIVITIES OF DAILY (ADLs)

	Before Disability	After Disability
Occupation		
Exact nature of occupational duties If the Life Assured is not working, please provide a list of the daily activities		
Name and address of business and employer		
Monthly income		
Date you last worked (dd/mm/yyyy)		
Date you returned to work Expected date of return * (*delete where appropriate) (dd/mm/yyyy)		

4) DETAILS OF DISABILITY

Please complete Question 1 to 5 if disability was DUE TO ACCIDENT			
1. Date of Accident (dd/mm/yyyy)			
2. Time of Accident	HR	MIN	☐ AM ☐ PM
3. Describe fully where and how did the accident happen?			
4. Describe the type and extend of injury.			
5. Was the accident reported to the Police?		☐ Yes ☐ No	

If Yes, please provide:

- the name of the police officer and police station at which the accident was reported; and
- A copy of the police report in this claim submission.

Please complete Question 6 to 9 if disability was DUE TO ILLNESS

6. Describe fully the signs or symptoms for which doctor was consulted and/or received treatment.

7. Date when signs or symptoms first started. (dd/mm/yyyy)	
8. Date when Life Assured first consulted a doctor for above signs or symptoms. (dd/mm/yyyy)	

9. Name and address of doctor(s) consulted.

5) DETAILS OF CONSULTATION / HOSPITALIZATION

1. Please provide the details of doctor or specialist whom Life Assured has consulted in connection with his/her illness/injury :-

Name of Doctor/ Specialist	Name and Address of Clinic/Hospital	Date of Consultations	Reason(s) for Consultation

2. Please provide the details of Life Assured's regular doctor and company doctor whom he/she has consulted for minor ailments (e.g. flu, cough, fever), high blood pressure, high cholesterol, diabetes etc:-

Name of Doctor/ Specialist	Name and Address of Clinic/Hospital	Date of Consultations	Reason(s) for Consultation

6) OTHER INSURANCE

1. Does Life Insured have similar benefits with other insurers?			☐ Yes ☐ No
If yes, please provide details below:			
Name of Insurer	**Type of Plan**	**Date of Issue (dd/mm/yyyy)**	**Sum Insured**

7) SETTLEMENT OPTION FOR APPROVED CLAIM

Please select your preferred mode of receiving the approved claim proceeds by ticking ☑ one of the boxes below:

☐ Issue a crossed cheque in my name and to be sent to my mailing address

☐ Issue a crossed cheque in my name and to be collected by my Representative

Name of Representative **Contact Number**

8) AUTHORISATION AND DECLARATION

1. I understand and agree that the submission of this form does not mean that my request will be processed. I understand that any payout under the policy shall be strictly in accordance with the policy terms and conditions.

2. I hereby declare that the information that is disclosed on this form is to the best of my knowledge and belief, true, complete and accurate, and that no material information has been withheld or is any relevant circumstances omitted. I further acknowledge and accept that China Life Insurance (Singapore) Pte. Ltd. ("CLIS") shall be at liberty to deny liability or recover amounts paid, whether wholly or partially, if any of the information disclosed on this form is incomplete, untrue or incorrect in any respect or if the Policy does not provide cover on which such claim is made.

3. I hereby warrant and represent that I have been properly authorised by the policyowner and the applicable insured(s) to submit information pertaining to such insured's claims.

4. I acknowledge and accept that the furnishing of this form, or any other forms supplemental thereto, by CLIS, is neither an admission that there was any insurance in force on the life in question, nor an admission of liability nor a waiver of any of its rights and defenses.

5. I acknowledge and accept that CLIS expressly reserves its rights to require or obtain further information and documentation as it deems necessary.

6. I confirm that I have paid in full all the bill(s)/invoice(s)/receipt(s) that I have submitted to CLIS for reimbursement and have not claimed and do not intend to claim from other company(ies)/person(s).

7. I agree to produce all original bill(s)/invoice(s)/receipt(s) that were submitted for reimbursement to CLIS for verification as it deems necessary.

8. I expressly authorise and consent to CLIS and its officers, employees and representatives collecting from, using and disclosing to any of the following persons, whether in Singapore or elsewhere, at their sole discretion, any and all information relating to the policyowner and the insured(s), including personal particulars, transactions and dealings with CLIS,:

   a) any doctor, hospital, clinic, insurance company;

   b) CLIS's holding companies, branches, representative offices, subsidiaries, related corporations or affiliates;

   c) any of CLIS's contractors or third party service providers or distribution partners or professional advisers or representatives; and

   d) any regulatory, supervisory or other authority, court of law, tribunal or person, in any jurisdiction, where such disclosure is required by law, regulation, judgement or order of court or order of any tribunal or as a matter of practice,

   for the purpose of processing, investigating and assessing this claim.

   I understand that CLIS has a Personal Data Protection Policy, which sets out the purposes for which personal data may also be used and disclosed, and it is available at www.chinalife.com.sg, which I confirm I have read and understood.

9. I agree to indemnify CLIS for all losses and damages that CLIS may suffer in the event that I am in breach of any representation and warranty provided to me herein.

I agree that this (i) CLIS shall have full access to the information stated in this form, and (ii) this authorisation and declaration shall form part of my proposed application for the relevant insurance benefits, and a photocopy of this form shall be treated as valid and binding as if it were the original.

_____

Name and Signature of Policy Owner/ Life Insured
(Policyholder to sign if Life Insured is a minor)

_____ _____

NRIC/ FIN/ Passport Number | Date (dd/mm/yyyy)

SECTION B – SPECIALIST REPORT

Total and Permanent Disability

(To be completed by the Life Assured's attending medical specialist)

Important Notes:
In order for us to process the claim, please submit all relevant clinical, radiological, histological, operation (if surgery has been performed), laboratory reports and other reports as follows with this Specialist Report.

1) INFORMATION ON SPECIALIST

Name of Specialist	
Field of Speciality	
Name of Medical Institution	

2) INFORMATION ON PATIENT

Name of Patient (as shown in NRIC/ Passport)	
NRIC / FIN / Passport Number	

3) MEDICAL RECORDS OF THE PATIENT

PART I	
1. Date when patient first consulted you for the condition? (dd/mm/yyyy)	
2. When was the last consultation? (dd/mm/yyyy)	
3. What were the presenting symptoms when you first saw the patient?	
4. When did the above symptoms first present? (dd/mm/yyyy)	
If the date is unknown, please state how long the symptoms had been present prior to date of the first consultation.	
5. What were your clinical and physical/mental findings when you first saw patient?	

Signature of the Specialist who complete Section B	Date

6. Please provide exact diagnosis :	
7. What is /are the underlying cause(s)?	
8. Date of Diagnosis. (dd/mmm/yyyy)	
9. Date when patient/ patient's next of kin first informed of the diagnosis. (dd/mm/yyyy)	
10. What was the exact information regarding diagnosis that patient or patient's next-of-kin was informed of?	

11. Please provide the details of patient's treatments (including any investigations/surgery administered) and his/her response to these treatments in chronological order. To **enclose copies** of the reports.

Date of treatment (dd/mm/yyyy)	Details of treatment	Investigation/ Surgery	Patient's treatment progress

12. Please provide details of the medications prescribed and if any medicines have been titrated since the initial onset of disability.		
13. Were you the doctor who first diagnosed the patient with this condition?	☐ Yes ☐ No	
14. If Yes to Question 13, over what period do your records extend? (dd/mm/yyyy)	From	To
15. If you are not the first doctor who diagnosed that patient with this condition, please provide:		
a. Name and address of the doctor who first made the diagnosis or had treated the patient for this condition.		
b. Date the diagnosis was made by the previous doctor. (dd/mm/yyyy)		
c. When was the referral made for the patient to see you? (dd/mm/yyyy)		

Signature of the Specialist who complete Section B	Date

d. What was the reason for referral to see you? Please attach a copy of the referral letter.
e. Please provide name and practice address of referral doctor.

PART II	
1. Date of last consultation. (dd/mm/yyyy)	
2. What were the symptoms and complaints reported by patient during the last consultation?	
3. What were your clinical and physical/mental findings when you last saw patient?	
4. Based on the last consultation assessment of patient's disability, please describe the nature and severity of patient's physical/mental impairment in respect of this illness or injury.	
5. As a result of the illness or injury, please state if patient's physical/mental impairment (as described in Question 4 above) had led to any of the following confinement requiring constant care and medical attention.	

Type of Confinement	**Please tick**	**Period of Confinement (dd/mm/yyyy)**	
		From	**To**
a. Home (Please specify)	☐ Yes ☐ No		
b. Hospital (Please specify)	☐ Yes ☐ No		
c. Bed	☐ Yes ☐ No		
d. Wheelchair	☐ Yes ☐ No		
e. Others (Please specify)	☐ Yes ☐ No		

Signature of the Specialist who complete Section B	Date

6. Is the patient able to perform (whether aided or unaided) the following Activities of Daily Living:

Activity	Please tick if the patient can perform the listed activity?	Period of inability to perform (dd/mm/yyyy)	
		From	To
Washing or bathing Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means. e.g. to wash the back, to wash hair	☐ Yes ☐ No		
Dressing Ability to put on, take off, secure and unfasten all garments (upper and lower) and, as appropriate, any braces, artificial limbs or other surgical or medical appliances. e.g. to button clothes, to put on trousers	☐ Yes ☐ No		
Feeding Ability to feed oneself food after it has been prepared and made available. e.g. to scoop food, to put food into mouth	☐ Yes ☐ No		
Toileting Ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances if appropriate. e.g. to get on or off the toilet	☐ Yes ☐ No		
Transferring Ability to move from a lying position on the bed to an upright chair or wheelchair, and vice versa. e.g. to be lifted up from lying position to sitting position from bed	☐ Yes ☐ No		
Mobility Ability to move indoors from room to room on level surfaces. e.g. to be supervised by someone closely in case of fall	☐ Yes ☐ No		

7. Please evaluate patient's level of functional ability based on the date of last consultation.

Activity	Date of evaluation (dd/mm/yyyy)	Please tick if the patient can perform the activity?	Date from which help was required (dd/mm/yy)	Please provide details.
Walking Walk more than 200m on a level surface continuously within 5 minutes, without having to stop because of breathlessness or severe pain.		☐ Yes ☐ No		
Fine Hand Control To remove 5 paracetamol pills from a blister pack within 60 seconds using your hand(s).		☐ Yes ☐ No		

Signature of the Specialist who complete Section B	Date

Activity	Date of evaluation (dd/mm/yyyy)	Please tick if the patient can perform the activity?	Date from which help was required (dd/mm/yy)	Please provide details.
Siting and Rising from a chair To sit and rise to a standing position from a wheelchair or chair (both with arms) of 40cm to 45cm in height.		☐ Yes ☐ No		
Lifting and Carrying To lift (from a bench with a height of 1 metre) and carry a 2kg weight for 10m and then placing it back down at bench height.		☐ Yes ☐ No		
Communicating To hear sounds of below 60 decibels in all frequencies of hearing or the ability to speak with sufficient clarity. Please attach ENT report.		☐ Yes ☐ No		
Eyesight Vision is measured at 6/60 or worse in one of the eyes using a Snellen eye chart, when tested with visual aids. Please attach Ophthalmologist report.		☐ Yes ☐ No		

8. To the best of your knowledge and Hospital records, what is the occupation and nature of duties reported by patient before he/she suffered the physical/mental incapacity?

9. To what extent does his/her physical/mental incapacity prevent him/her from performing all the normal duties of his/her usual occupation?

Signature of the Specialist who complete Section B	Date

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10. If he/she cannot return to his/her usual occupation, can he/she engage in any other types of occupation?	☐ Yes ☐ No
a. If Yes, please provide details for the following:-	
i. When do you think the patient will be able to return to work, either part-time or full-time?	
ii. What are the types of occupation he/she can engage in?	
b. If No, please provide details for the following:-	
i. Give details on any social, domestic or employment issues that are, or have been, impacting the patient's ability to work?	
ii. Please describe how the physical/mental impairments prevent the patient from ever continuing in any occupation, business or activity which pays him/her an income.	
iii. When did such disability commence? (dd/mm/yyyy)	
11. Is the patient suffering from total loss of hearing in both the ears? Please tick.	☐ Yes ☐ No
a. Please provide the actual readings on the extent of hearing loss for both ears. Please provide **copies of audiogram and sound-threshold tests**.	
Left ear loss of hearing: decibels	Right ear loss of hearing: decibels
b. Is the hearing loss irreversible? Please tick	☐ Yes ☐ No
12. Is the patient suffering from total loss of ability to speak? Please tick.	☐ Yes ☐ No
a. Is the loss of ability to speak as a result of injury or disease to the vocal cord? Please tick.	☐ Yes ☐ No
b. Is the loss of ability to speak total and irrecoverable? Please tick.	☐ Yes ☐ No
c. Did the inability to speak last for a continuous period of 12 months? Please tick.	☐ Yes ☐ No
d. Please state the period of inability to speak. (dd/mm/yyyy)	FROM TO
e. Is the loss of ability to speak associated with any psychiatric condition? Please tick.	☐ Yes ☐ No

Signature of the Specialist who complete Section B	Date

13. Is the patient suffering from total and irrecoverable loss of use of both eyes? Please tick.	☐ Yes ☐ No

a. What is the patient's current visual acuity of both eyes using Snellen eye chart and patient's current visual field in both eyes?

Visual acuity on **left eye**: Visual acuity on **right eye**:

Date of assessment: (dd/mm/yyyy) Date of assessment: (dd/mm/yyyy)

Visual field on **left eye**: Visual field on **right eye**:

Date of assessment: (dd/mm/yyyy) Date of assessment: (dd/mm/yyyy)

14. Is the patient suffering from total and irrecoverable loss of use of any two limbs, excluding hands and feet? Please tick.	☐ Yes ☐ No
Please explain in details.	
15. Is the patient suffering from total and irrecoverable loss of use of one eye and any one limb excluding hands and feet? Please tick.	☐ Yes ☐ No
Please explain in details.	
16. In accordance to the Singapore's Mental Capacity Act (Cap 177A), is the patient mentally incapacitated? Please tick.	☐ Yes ☐ No

Part III

1. Please tick your reply to Question (a) to (e) below, if patient's condition or surgery performed in any way related to or due to:

a. Attempted suicide or self-inflicted injuries?	☐ Yes ☐ No
b. AIDS, AIDS-related complex or infection by HIV?	☐ Yes ☐ No
c. Congenital or hereditary diseases or disorder?	☐ Yes ☐ No
d. Mental and personality disorders (excluding Dementia and Alzheimer's disease)?	☐ Yes ☐ No
e. Improper use of alcohol, alcohol abuse or alcohol dependence?	☐ Yes ☐ No

Signature of the Specialist who complete Section B	Date

If you have answered Yes to any of the above Question 1(a) to 1(e), please provide details:

Diagnosis	Date of diagnosis (dd/mm/yyyy)	Name and practice address of treating doctor

2. Has the patient previously consulted you or any other doctor for treatment or advice for this disability condition or any related condition? If yes, please provide the following details: ☐ Yes ☐ No

Diagnosis	Date of diagnosis (dd/mm/yyyy)	Date when patient was informed of diagnosis (dd/mm/yyyy)	Name and date of treatments (dd/mm/yyyy)	Name and practice address of treating doctor

3. Is there anything in patient's medical history which would have increased the risk of having his/her condition? ☐ Yes ☐ No

If yes, please state the details.

4. Does the patient have or ever had any other significant health condition? If yes, please provide the following details. ☐ Yes ☐ No

Diagnosis	Date of diagnosis (dd/mm/yyyy)	Date when patient was informed of diagnosis (dd/mm/yyyy)	Name and date of treatments (dd/mm/yyyy)	Name and practice address of treating doctor

Name and Signature of the Specialist who filled up Section B	Date
Practice Stamp of the Specialist	