Life Insurance Corporation(Singapore)Pte Ltd
3,Raffles Place, #10-01,Bharat Building
Singapore 048617 Phone +65 62234797
email ID:- crm@licsingapore.com

PERMANENT DISABILITY CLAIM FORM: PART 1- CLAIMANT'S STATEMENT

INSTRUCTIONS

This form is to be completed by the life assured. If the life assured is aged below 18, then the proposer should fill this form.

The cost for the medical specialist's statement and other hospital records are to be borne by the claimant.
Please submit the forms and documents to our office in the address mentioned here.

A. POLICY DETAILS		
Policy Number(s)		
B. PARTICULARS OF THE LIFE ASSURED		
Name of the Life Assured	Date of Birth (dd/mm/yyyy)	NRIC No. (If life assured is not a Singapore Citizen, please provide FIN / Passport No.)
Occupation & Nature of work	Annual Income from employment	Name and address of the employer
C.PARTICULARS OF THE CLAIMANT (if other than the life assured)		
Name of the Claimant	Contact Number	NRIC No. (If claimant is not a Singapore Citizen, please provide FIN / Passport No.)
Claimant's Address	Relationship to the life assured	Capacity / Title under which the claim is made.

D. PARTICULARS OF THE DISABILITY	
1. Describe the nature of disability of the life assured.	
2. Is the life assured attending to work? If not, which was the last day at work?	
3.The date by which the life assured is expected to return to work.	
4. Describe the daily activities that the life assured is unable to perform after the disability.	

E. TREATMENT PARTICULARS

1.The date when the disability was first diagnosed / occurred.	_____/____/_____ (dd/mm/yyyy)
2.The date when a physician was first consulted for this condition.	_____/____/_____ (dd/mm/yyyy)

F.DETAILS OF ALL PHYSICIANS CONSULTED .Please attach a separate sheet if additional space is required.

Name of the Doctor	Name and Address of Clinic / Hospital	Date of consultation	Purpose of Visit

G. IF DISABILITY IS DUE TO ACCIDENT

1.Please state the place ,date and time of the accident	Place of Accident	Date of Accident (dd/mm/yyyy)	Time of Accident
2. Description of the Accident			
3.Was the accident reported to the police?	☐ Yes ☐ No	If 'Yes', submit a certified copy of the Police Investigation Report	

H. OTHER INSURANCE DETAILS: Please attach a separate sheet if additional space is required.

Is the life assured insured with other companies for similar benefits?	☐ Yes ☐ No .If 'Yes', please give details below				
Name of the Company	Policy Number	Date of Issue (dd/mm/yyyy)	Sum Insured (S$)	Date of intimation of claim	Status of the claim

I. DECLARATION BY THE CLAIMANT

1.I, _____ hereby declare that the above statements are true and complete and that I have not withheld any material fact from Life Insurance Corporation and I make this solemn declaration believing it to be true and by virtue of the provisions of the Statutory Declaration Act,1835.

2.I hereby consent to Life Insurance Corporation from seeking information from any hospital,physician,person or organisation that maybe required regarding the life assured and I authorise the giving of such information to Life Insurance Corporation for assessing the claim.Any fees payable for such medical reports will be borne by me.
A photocopy of this authorisation shall be considered as valid as the original.

_____ _____

Date(dd/mm/yyyy) Signature of the Claimant

Life Insurance Corporation(Singapore)Pte Ltd
3 Raffles Place,#10-01,Bharat Building
Singapore 048617 Phone +65 62234797
email ID:- crm@licsingapore.com

PERMANENT DISABILITY CLAIM FORM: PART 2 - PHYSICIAN'S STATEMENT

(To be completed by the attending Medical specialist)

Please attach all relevant investigation reports. The cost of the reports will be borne by the patient / claimant of the insurance policy.

1. Name of the patient	NRIC / Passport number	Occupation

2.The date when the disability occurred /diagnosed	(dd/mm/yyyy)
3.The date when the patient first consulted you for this condition	(dd/mm/yyyy)
4.The date when the patient last consulted you for this condition	(dd/mm/yyyy)

5. Was the disability caused by an accident? If Yes, give details.
6. Describe the disability of the patient.
7. Has the patient ever had a similar condition earlier? If Yes, give details.
8. Is the patient capable of returning to work or taking up other employment? Give details.

6. Give details of treatment / surgical procedures carried out in connection with this condition.

7. What investigations and tests were conducted for the diagnosis / treatment?

8. Details of all the doctors / hospitals the patient has been to in connection with this condition

Name & address of Physician / Hospital	Dates of consultation	Purpose of consultation

9. List of hospital reports attached:

Name of the Doctor :_____

Qualification : _____

Signature : _____

Date: : _____ Hospital / Official Stamp