

## ElderShield CLAIM FORM

Dear Policyholder,

We are sorry to learn of your disability.

In order for us to process your claim, please:

1. Complete the attached 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 severe disability assessment. Please refer to the attached list of appointed assessors. The fee for the assessment is to be paid by you.
3. Bring along the following for the appointment:
  - Completed Claim Form
  - Hospital medical records and discharge summary that you may have
  - Medicine (if any)

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

If you need help, please contact our staff at **6827 7788** or email us at [cs\\_life@aviva-asia.com](mailto:cs_life@aviva-asia.com).

## 乐龄健保 索赔表格

敬爱的保单用户，

我们十分同情您的处境，也希望尽快地给予保单赔偿。

为了尽快地处理您的索赔申请，请您：

1. 填妥后面附的索赔表格。如果自己无法填写，可请亲属或看护人代为填写。
2. 从后面所附的合格评估员名单中选出一名评估员，并预约评估时间，请他评估您的残疾情况。不过，评估费自理。
3. 在评估当日携带下列文件赴约：
  - 填妥的索赔表格
  - 完整的病历和出院单(如有)
  - 正在服用的药物(如有)

一旦收到全部所需资料，我们会尽快处理您的索赔，并及时通知您索赔的结果。

若您需要协助，请联络 **Aviva 6827 7788** 或电邮于 [cs\\_life@aviva-asia.com](mailto:cs_life@aviva-asia.com)。

## ElderShield BORANG TUNTUTAN

Pemegang Polisi,

Kami bersimpati di atas keadaan kesihatan anda.

Untuk memproses tuntutan anda itu, sila:

1. Isikan borang tuntutan anda. Jika anda tidak berupaya mengisi borang tersebut, keluarga anda boleh membantu mengisi borang itu.
2. Hubungi klinik untuk membuat temu janji bersama pegawai penilaian untuk menilai kesihatan anda. Sila rujuk pada senarai nama-nama pegawai penilaian yang telah dilantik. Anda dikehendaki membayar yuran bagi penilaian anda.
3. Bawa bersama dokumen-dokumen berikut sewaktu penilaian itu:
  - Borang Tuntutan anda yang telah dilengkapi
  - Rekod kesihatan anda dari hospital dan juga surat pengesahan pesakit (Inpatient discharge summary)
  - Ubat-ubat anda (jika ada)

Kami akan memproses tuntutan anda setelah menerima segala dokumen yang diperlukan dan akan menghubungi anda secepat mungkin.

Jika anda memerlukan bantuan, sila hubungi kami di **6827 7788** atau emel kami di **cs\_life@aviva-asia.com**.

## எல்டர்ஷீல்டு கோரிக்கை படிவம்

அன்புடையீர்

தங்களுக்கு ஏற்பட்டுள்ள இயலாமை நிலை அறிந்து வருந்துகிறோம்.

மேற்கொண்டு நாங்கள் செயலாற்ற பின் வருவனவற்றை செய்யுங்கள்.

1. இணைக்கப்பட்டுள்ள கோரிக்கை படிவத்தை தங்களால் இயன்ற வரை பூர்த்தி செய்யுங்கள். தங்களால் இயலவில்லை என்றால் நெருங்கிய குடும்ப உறுப்பினரோ அல்லது தங்களைத் தற்போது கவனித்துக்கொள்பவரோ பூர்த்தி செய்யலாம்.
2. மருத்துவ பரிசோதனை செய்துகொள்ள நாள் குறிக்க மருந்தகத்தை அழையுங்கள். இணைக்கப்பட்டுள்ள நியமன ஆய்வாளர் பட்டியலைக் காண்க. மருத்துவ பரிசோதனை கட்டணத்தை நீங்கள் கொடுக்க வேண்டும் என்பதை தெரிவித்துக்கொள்கிறோம்.
3. பரிசோதனைக்கு செல்லும் போது பின் வருவனவற்றை எடுத்துச் செல்லுங்கள்:
  - பூர்த்தி செய்த கோரிக்கை படிவம்
  - உங்களிடம் இருக்கிற நோய் தொடர்பான தகவல்கள் (Medical Reports)
  - உட்கொள்ளும் மருந்துகள் (முடிந்தால்)

அனைத்து தகவல்களும் சான்றிதழ்களும் எங்களுக்கு கிடைத்தவுடன் உங்கள் கோரிக்கையை பரிசீலனை செய்து முடிவை உங்களுக்கு தெரியப்படுத்துவோம்.

உங்களுக்கு உதவி தேவைப்பட்டால் தயவு செய்து **6827 7788** எண்ணுக்கு அழைக்கவும் அல்லது **cs\_life@aviva-asia.com** என்று மின்னஞ்சல் செய்யவும்.

# ELDERSHIELD CLAIM FORM

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



**BASIC ELDERSHIELD** Policy No.: \_\_\_\_\_ Insurer: Aviva Ltd / Great Eastern / NTUC Income\*  
**SUPPLEMENTARY ELDERSHIELD** Policy No.: \_\_\_\_\_ Insurer: Aviva Ltd / Great Eastern / NTUC Income\*

## 1: PERSONAL PARTICULARS

### POLICYHOLDER

Name of Policyholder

NRIC No.	Nationality	Date of Birth (DD/MM/YY)	Ethnic Group Chinese/ Malay/ Indian/ Others*	Gender Male/ Female*
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Address

Contact Number (Home)	(Handphone)	Email
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### CAREGIVER

Name of Main Caregiver (Full-time/ Part-time\*)

Relationship to Policyholder	NRIC No.	
Contact Number (Home)	(Handphone)	Email

### BANK ACCOUNT DETAILS (IMPORTANT – Please do not leave blank.) Please pay to the following bank account of the policyholder once the claim is admitted.

Name of Bank Account Holder+	Bank Account No.
Name of Bank	Name of Branch

+ For payment to third party (family member/ caregiver), please indicate the name of intended payee in the box "Name of Bank Account Holder" above. A separate Letter of Undertaking & Indemnity will be sent for the third party's completion when the claim becomes payable.

## 2: MEDICAL HISTORY

Q1 Have you ever been admitted to hospital in the last 5 years? Yes / No\*  
If Yes, please give details of the medical conditions and when it started.

Condition	Date Started

Q2 Please state other medical conditions, if any (e.g. stroke, hypertension, heart disease, diabetes mellitus), that you are suffering from.

\_\_\_\_\_

Q3 Name and address of your regular doctor.

\_\_\_\_\_

Q4 If disability is due to accident, please provide date of accident: \_\_\_\_/\_\_\_\_/\_\_\_\_(dd/mm/yy), and attach a copy of accident report. If no report is available, please describe: (a) nature of the accident, and (b) extent of injuries

\_\_\_\_\_

\* Please delete accordingly

### 3: ACTIVITIES OF DAILY LIVING

Please tick against the box that most accurately describes the policyholder's ability	Date disability started
<p><b>Q1 WASHING OR BATHING</b> – 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><b>Q2 DRESSING</b> – 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.</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><b>Q3 FEEDING</b> – 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><b>Q4 TOILETING</b> – 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 to be placed on the toilet and cleaned by caregiver).</p> <p><input type="checkbox"/> Not able to do at all (needs caregiver to manage diapers and/or catheter).</p>	
<p><b>Q5 TRANSFERRING</b> – 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 up 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>	
<p><b>Q6 MOBILITY</b> – 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>	

### DECLARATION

1. I hereby declare that the above statements are true and complete and I have not withheld any material fact from Aviva Ltd.
2. I agree that:
  - a. this declaration shall form part of my application for ElderShield benefits.
  - b. this claim signifies my consent to the Insurer to obtain medical information from any doctor whom I have consulted and I authorise the doctor to release such information to the Insurer.
  - c. the Insurer may release any relevant information concerning me (including my medical information) to any third party, which the Insurer deems necessary.
  - d. any third party who has received any information concerning me may also obtain medical information from any doctor whom I have consulted, and I authorise the doctor to release such information to the third party. The third party may also release relevant information concerning me (including my medical information) to any other party for any purposes related to my application or claim for ElderShield benefits.
  - e. a photocopy of this form shall be treated as valid and binding as if it were the original.

Name of Policyholder	NRIC/Passport No.	Signature/Thumb Print of Policyholder	Date
To be completed if form is filled up by family members/ caregiver			
Name of family member/ caregiver*	Signature of family member/ caregiver*		
Relationship to Policyholder	Date		

\* Please delete accordingly