TOKIO MARINE
INSURANCE GROUP

GROUP TOTAL & PERMANENT DISABILITY CLAIM FORM

Dear insured employee,

We are sorry to learn about your illness/accident.

In order for us to process your claim, we require the following:

(1) Group Total & Permanent Disability Claim Form
(2) Medical Report (medical fee to be borne by insured employee)
(3) Certified copy of NRIC / Passport by authorized officer of employer / company
(4) Consent Form for Medical Report
(5) Medically boarded out report / letter from employer/company
(6) Available laboratory and test results
(7) Copy of police report, if any (for disability due to accident)

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

Upon approval of the claim, the claim cheque will be made in favour of the employer / company.

GROUP TOTAL & PERMANENT DISABILITY CLAIM FORM

IMPORTANT NOTES :
(1) The issue of this claim form is not an admission of liability.
(2) This claim form is to be completed by the employer & insured employee.
(3) Tokio Marine Life Insurance Singapore Ltd. ("TMLS") reserves the right to request for additional medical reports when it deems necessary.

PART 1 : TO BE COMPLETED BY THE EMPLOYER

Name of employer: _____

Subsidiary/cost centre: _____ Group policy no: _____

Name of employee: _____ Benefit plan : _____

NRIC / passport no.: _____ Marital status : _____ Sum assured : _____

Date of birth (dd/mm/yyyy) : _____ Date of employment : _____ Gender : ☐ Male ☐ Female

Designation : _____

Personal Data Notice

We represent to, warrant and undertake with TMLS that collective consents have been obtained from each of the employees and their respective life assureds and dependants allowing TMLS to collect, use, process and disclose the personal data in accordance with the terms and conditions as stated in the insurance application form or TMLS's Data Protection Policy available at www.tokiomarine.com, which we / they have read, understood and agreed to the same.

_____ _____

Authorised Signature & Date (dd//mm/yyyy) Company Stamp

Name: _____ NRIC / Passport No: _____

Designation: _____ Email: _____

PART 2 : TO BE COMPLETED BY INSURED EMPLOYEE

DETAILS OF CLAIM:

2.1 Was the disability suffered due to? ☐ Illness ☐ Accident

(a) If it was due to an illness, please provide the following information :

(i) Please describe fully the symptoms for which you have consulted a doctor :

_____

(ii) Since when did you have the symptoms before you consulted a doctor? _____ (dd/mm/yyyy)

(iii) Date when you first consulted a doctor? _____ (dd/mm/yyyy)

(iv) Describe fully the extent and nature of the illness :

_____

_____

_____ _____

Signature of Insured Employee Date (dd/mm/yyyy)

Tokio Marine Life Insurance Singapore Ltd. (Company Reg. No.: 194800055D)
20 McCallum Street, #07-01 Tokio Marine Centre, Singapore 069046 T: (65) 6592 6100 F: (65) 6223 9120 W: tokiomarine.com

(b) If it was due to an accident, please provide the following information :

(i) Date of accident : _____ (dd/mm/yyyy) Time of accident : _____

Place of accident : _____

(ii) Describe in detail how the accident happened :

_____

_____

(iii) Please describe the nature and extent of injuries sustained :

_____

_____

(iv) Was there any eye-witness to the accident? ☐ Yes ☐ No

If **yes**, please give name(s) and address(es) of witness(es) :

Name of witness	Address

(v) Was the accident reported to the police? ☐ Yes ☐ No

If **yes**, please give the name of the police station reported to (please enclose a copy of the police report)

_____

2.2 What is the date when you last worked prior to disability : _____ (dd/mm/yyyy)

2.3 Are you currently confined to ☐ Bed? ☐ House? ☐ Wheelchair? ☐ Neither?

2.4 Are you able to perform without assistance on the following activities of daily living :

(a) Eating? ☐ Yes ☐ No

(b) Walking? ☐ Yes ☐ No

(c) Dressing? ☐ Yes ☐ No

(d) Bathing? ☐ Yes ☐ No

(e) Using the Toilet? ☐ Yes ☐ No

(f) Getting in and out of Bed? ☐ Yes ☐ No

2.5 Date when you returned to work or expected to return to work : _____ (dd/mm/yyyy)

DETAILS OF MEDICAL CONSULTATIONS / HOSPITLISATION:

3.1 Please provide details of doctor(s) whom you have consulted in connection to your illness / injury

Name of doctor / hospital	Address	Date of first consultation / hospitalisation

_____ _____

Signature of Insured Employee Date (dd/mm/yyyy)

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3.2 Please provide details of your regular doctor(s), date and reason(s) of consultation :

Name of doctor	address	Date of consultation	Reason(s) of consultation

DETAILS OF OTHER INSURANCES:

4.1 Are you insured with other insurance company(ies)? ☐ Yes ☐ No

If **yes**, please provide the following details :

Name of insurance company	Date of issue	Sum assured	Type of plan	Claim amount	Claim notified
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Personal Data Notice

I agree and consent that Tokio Marine Life Insurance Singapore Ltd. ("TMLS") may collect, use, process and disclose the personal data in accordance with the terms and conditions as stated in the insurance application form and/or TMLS's Data Protection Policy available at www.tokiomarine.com, which I have read, understood and agreed to the same.

Declaration

I declare that all answers given by me in this form is in every respect true and correct and that no material information has been withheld nor any relevant circumstances omitted.

I hereby authorize:

(a) any medical source, insurance office, or organization to release to or when requested to do so by TMLS, any relevant information concerning the below-named employee, and;

(b) TMLS to release to any medical source, insurance office, or organization, any relevant information concerning the below-named employee, at any time.

A photocopy of this authorization shall have the same effect as the original.

_____ _____

Signature of insured employee Date (dd/mm/yyyy)

Name of insured employee: _____ NRIC No.: _____

Contact No(s) : _____ Email: _____

Address: _____

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GROUP TOTAL & PERMANENT DISABILITY CLAIM
MEDICAL REPORT FORM

1 Name of patient : _____
(as stated in NRIC / Passport)

2 NRIC / passport no. : _____

3 DETAILS OF CONSULTATION / TREATMENT

(a) Diagnosis : _____

(b) Date of first consultation with you : _____
(dd/mm/yyyy)

(c) Please state symptoms presented and date symptoms first appeared in the box provided below :

Symptoms presented at first consultation	Date symptoms first started (dd/mm/yyyy)

(d) Date of diagnosis : _____
(dd/mm/yyyy)

(e) Diagnosis was first made by (name of doctor) : _____

(f) Date when diagnosis was first made known to the patient _____
(dd/mm/yyyy)

(g) Was the condition a result of an accident? ☐ Yes ☐ No
If **yes**, please state date of accident: _____
(dd/mm/yyyy)

(h) Describe in details how the accident happened:

_____

(i) Was the accident being reported to police? ☐ Yes ☐ No
If **yes**, please give the name of the police station reported to (please enclose a copy of the police report).

_____

(j) Was the cause of the patient's condition / injury a result of self-destruction / intentional self-infliction? ☐ Yes ☐ No
If **yes**, please provide full details:

_____

Hospital / Clinic Stamp

Date (dd//mm/yyyy) _____

Signature of Attending Doctor

Name and Address

Qualification

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(k) Was the patient under the influence of alcohol or drugs at the time of accident? ☐ Yes ☐ No

(l) Last occupation before disability occurred : _____

(m) Nature of duties of last occupation : _____

(n) Is the patient currently working? ☐ Yes ☐ No
If **yes**, what is the occupation?

_____

(o) Nature of duties of current occupation : _____

4 CURRENT HEALTH STATUS OF PATIENT'S ILLNESS / INJURY

(a) Kindly describe the nature and severity of the patient's illness / injury :

_____

_____

(b) Date the patient last consulted you : _____ (dd/mm/yyyy)

(c) Is the patient's disability ☐ Progressive? ☐ Stationary? ☐ Improving? ☐ Recovered?

(d) Is full recovery expected? ☐ Yes ☐ No
If **yes**, please state approximate date : _____ (dd/mm/yyyy)
If **no**, please state the extent of recovery and approximate date:

_____

(e) Is the patient able to perform without assistance on the following activities of daily living?

(i) Eating? ☐ Yes ☐ No

(ii) Walking? ☐ Yes ☐ No

(iii) Dressing? ☐ Yes ☐ No

(iv) Bathing? ☐ Yes ☐ No

(v) Using the toilet? ☐ Yes ☐ No

(vi) Getting in and out of bed? ☐ Yes ☐ No

(f) What is the patient's current state of mobility?

☐ Confined to a home. ☐ Confined to hospital.
☐ Confined to other institution that provides constant care and medical attention.

(g) Does the patient have full power of all limbs? ☐ Yes ☐ No
If **no**, please specify which limb(s) that do(es) not have full power and the current power of the limbs

_____

(h) Please give full details with respect to the patient's current mental abilities and cognitive abilities:

_____

_____

_____ _____

Hospital / Clinic Stamp | Signature of Attending Doctor

Date (dd//mm/yyyy) _____ | Name and Address

Qualification

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(i) Is the patient able to perform all the duties of his/her last occupation as listed under No 3(l)? ☐ Yes ☐ No

If **yes**, when is the patient expected to return to his/her occupation? _____ (dd/mm/yyyy)

(j) If the patient is unable to return to his / her usual occupation, is he / she able to engage in any other occupation? ☐ Yes ☐ No

If **yes**, what type of occupation(s) can he/she engage in?

_____

(k) When is the patient expected to engage in the occupation(s) as mentioned under No. 4(j)?

_____

(l) In your opinion, is the disability "total and permanent" and such that there is neither then nor at any time thereafter any work, occupation or profession that the patient can ever sufficiently do or follow to earn or obtain any wages, compensation or profit? ☐ Yes ☐ No

If **Yes**, when did such disability commenced? _____ (dd/mm/yyyy)

5 MEDICAL HISTORY OF PATIENT

(a) Did the patient consult other doctors for this illness / injury or its symptoms prior to consulting you? ☐ Yes ☐ No

If **yes**, please give name(s) and address(es) of the doctor(s) whom the patient has consulted :

Name of Doctor	Name of clinic / hospital and address

(b) Is the patient suffering from or has suffered from any other significant illness? ☐ Yes ☐ No

If **yes**, please state below :

Illness	Date of first diagnosis (dd/mm/yyyy)	Name and address of attending doctor

(c) Are you the patient's regular doctor? ☐ Yes ☐ No

If **yes**, since when? _____ (dd/mm/yyyy)

If **no**, please state the name and address of the patient's regular doctor :

_____

6 Kindly provide us with additional information, if any, to further assist us in assessing this claim :

_____

_____

_____

_____ _____

Hospital / Clinic Stamp | Signature of Attending Doctor

Date (dd//mm/yyyy) _____ | Name and Address

Qualification

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CONSENT FORM FOR MEDICAL REPORT

NAME OF PATIENT : _____

NRIC NO. : _____ POLICY NO. : _____

This consent form is required for an insurance claim.

Authorization

I hereby authorize:

(a) any medical source, insurance office, or organization to release to or when requested to do so by Tokio Marine Life Insurance Singapore Ltd. ("TMLS"), any relevant information concerning the above-named patient, and;

(b) TMLS to release to any medical source, insurance office, or organization, any relevant information concerning the above-named patient, at any time.

A photocopy of this authorization shall have the same effect as the original.

Yours faithfully

_____

Signature of *Patient / Patient's Parent / Next-Of-Kin

Name : _____

Address : _____

_____

Relationship to Patient : _____ NRIC No. : _____

* Delete accordingly

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