



INDIVIDUAL TOTAL & PERMANENT DISABILITY (TPD) CLAIM FORM

Dear claimant,

We are sorry to learn about your disability.

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

- (1) Claimant's Statement
- (2) Doctor's Statement (medical fee to be borne by policyholder)
- (3) Declaration of Beneficial Ownership (for Trust / Keyman Policies)
- (4) Consent Form For Medical Report
- (5) Authorisation Form For Crediting to Singapore Bank Account
- (6) Available laboratory and test results, diagnostic scan reports
- (7) Copy of police report (if disability is due to an accident)
- (8) Copy of physical NRIC of claimant and life assured
- (9) Proof of relationship for 3rd party policies
- (10) All documents which are in foreign language must be officially translated to English (translated by official Authority / Notary Public / Embassy) before submitting to us.

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

Submission of Claim Documents

Please submit all claim documents:

- (I) Through your servicing adviser; OR
- (II) By post to the below address:

Life Claims Department
Tokio Marine Life Insurance Singapore Ltd
20 McCallum Street
#07-01 Tokio Marine Centre
Singapore 069046



INDIVIDUAL TOTAL & PERMANENT DISABILITY (TPD) CLAIM CLAIMANT'S STATEMENT

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 Assured.
- (3) Tokio Marine Life Insurance Singapore Ltd. reserves the right to request for additional medical reports when it deems necessary.

PART 1: DETAILS OF POLICY(IES)

1.1 Policy No. : (a) _____ (b) _____
(c) _____ (d) _____

PART 2: DETAILS OF ASSURED

2.1 Name : _____
(as stated in NRIC / Passport)

2.2 NRIC / Passport No. : _____

2.3 Residence address : _____

2.4 Occupation : _____

2.5 Contact No. : _____ (H) _____ (O) _____ (HP)

PART 3: DETAILS LIFE ASSURED [if different from Part (2)]

3.1 Name : _____
(as stated in NRIC / Passport)

3.2 NRIC / Passport No. : _____

3.3 Residence address : _____

3.4 Contact No. : _____ (H) _____ (O) _____ (HP)

PART 4: DETAILS OF LIFE ASSURED'S OCCUPATION

	<u>Before disability</u>	<u>After disability</u>
4.1 Occupation :	_____	_____
4.2 Name of employer. :	_____	_____
4.3 Average monthly income for 1 year :	_____	_____
4.4 List exact duties performed at work :	_____	_____

Note :

- (a) If the Life Assured is not working, kindly provide a list of daily activities before and after the disability.
- (b) The Company reserves the right to request for supporting documentary evidence.

Signature of Assured

Date (dd/mm/yyyy)

(2024.03)



PART 5: DETAILS OF ILLNESS(ES) / MEDICAL CONDITION(S) OF LIFE ASSURED

5.1 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 the Life Assured consulted a doctor :

(ii) Since when did the Life Assured have the symptoms before he / she consulted a doctor?

_____ (dd/mm/yyyy)

(iii) Date when the Life Assured **first** consulted a doctor?

_____ (dd/mm/yyyy)

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

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

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

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) :

Signature of Assured

Date (dd/mm/yyyy)

(2024.03)



5.2 Date the Life Assured last worked prior to disability (dd/mm/yyyy): _____

5.3 Is the Life Assured currently confined to? Bed House Wheelchair Neither

5.4 Is the Life Assured able to perform without assistance on the following activities of daily living :

- | | | |
|--------------------------------|------------------------------|-----------------------------|
| (a) Eating? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| (b) Walking? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| (c) Dressing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| (d) Bathing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| (e) Using the Toilet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| (f) Getting in and out of Bed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

PART 6: DETAILS OF MEDICAL CONSULTATIONS / HOSPITALISATION

6.1 Please provide details of doctor(s) whom the Life Assured has consulted in connection to his / her illness / injury :

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

6.2 Please provide details of the Life Assured's regular doctor(s), date and reason(s) of consultation :

Name of doctor/ Name of clinic	Address	Date of first consultation	Date of last consultation	Reason(s) for consultation

5.2 Date the Life Assured last worked prior to disability (dd/mm/yyyy): _____

5.3 Is the Life Assured currently confined to? Bed House Wheelchair Neither

PART 7 : OTHER INSURANCES

7.1 Was the Life Assured 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
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of Assured

Date (dd/mm/yyyy)

(2024.03)



PART 8: DECLARATION FOR COMMON REPORTING STANDARD (CRS)

8.1 Please provide information on your Tax Residency. (This will usually be where you are liable to pay income taxes.)

	Country of Tax Residence	Taxpayer Identification Number (TIN) <i>In Singapore, TIN for Individuals would be your NRIC/FIN</i>	If no TIN available, enter Reason A, B or C	Please state reason(s) if Reason B is selected
Proposer				
Joint Life Assured				

If you are a tax resident in more than two countries, please use a separate Individual Tax Residency Self-certification Form. If a Taxpayer Identification Number (TIN) is unavailable, please provide the appropriate reason A, B or C:

- Reason A** The country where you are liable to pay tax does not issue TINs to its residents.
- Reason B** You are otherwise unable to obtain a TIN or equivalent number (Please explain why you are unable to obtain a TIN in the below table if you have selected this reason).
- Reason C** No TIN is required. (Note: Only select this reason if the authorities of the country of tax residence entered below do not require a TIN to be disclosed).

For more information on Common Reporting Standard, you can refer to our company website.
<http://www.tokiomarine.com/sg/en/about-us/crs.html>

For Entity and/or Controlling Persons, please complete the Entity Tax Residency Self-Certification Form and/or Controlling Person Tax Residency Self-Certification Form (forms can be obtained from the same website). If you have any questions on how to define your tax residency status, please visit the IRAS website or speak to a professional tax adviser as we are not allowed to give tax advice.

Signature of Assured
Date (dd/mm/yyyy)



Personal Data Notice

I / We agree and consent that Tokio Marine Life Insurance Singapore Ltd. and Tokio Marine Insurance Singapore Ltd. (“Tokio Marine Insurance Group”) 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 the Tokio Marine Insurance Group’s Data Protection Policy available at www.tokiomarine.com which I / we have read, understood and agreed to the same.

Declaration

I / We agree that:-

- (i) all answers given by me / us in this form are, to the best of my / our knowledge and belief, true and complete;
- (ii) Tokio Marine Life Insurance Singapore Ltd (“TMLS”) shall not be deemed to provide cover and neither should TMLS be liable to pay any claim, provide any benefit under the Policy/relevant Policy or be required to process any request made to the extent that the provision of such cover, payment of such claim, provision of such benefit or processing of such request would expose TMLS (or its parent company or holding company (in both instances, whether direct or indirect) or the subsidiaries of its parent or holding company) to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the applicable jurisdiction, Singapore, the European Union, United Kingdom or United States of America;
- (iii) where TMLS becomes aware that I/We, the Life Assured or any person or entity connected with the Policy/relevant Policy (see paragraph (iv) below) is/are subject to any sanction, prohibition or restriction under such resolutions, trade or economic sanctions, laws or regulations mentioned in paragraph (ii), TMLS shall be entitled to block, suspend and/or terminate the Policy/relevant Policy at any time including but not limited to, not making or receiving any payments under the Policy/relevant Policy. The decision of TMLS on the aforementioned is final; and
- (iv) a person or entity connected with the Policy/relevant Policy includes an assignee, a beneficiary, a trustee, an executor, an administrator, a director or direct/indirect shareholder or person having executive authority or natural persons appointed to act on my/our behalf, for my/our beneficial owners or beneficiaries’ beneficial owners. As an ongoing obligation, I/We will immediately inform TMLS if there are any changes to the identities, status/constitution/establishment, particulars and identification documents of these persons.

I / We hereby also 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 assured, and;
- (b) TMLS to release to any medical source, insurance office, or organization, any relevant information concerning the below-named assured, at any time.

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

	Signature of Assured	Date
Name(s) :		
NRIC No(s) :		
Address(es) :		
(Note: Our correspondence will be sent to your policy’s mailing address. If you have moved, please update your mailing address via TMLS Policyholders Portal https://mypolicy.tokiomarine-life.sg before submitting this claim.)		
Email Address :		
Contact No(s) :	(HP)	
Relationship to Life Assured :		



INDIVIDUAL TOTAL & PERMANENT DISABILITY (TPD) CLAIM DOCTOR'S STATEMENT

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) What is the date of last consultation with you before completion of this
Doctor's Statement? _____
(dd/mm/yyyy)

(d) 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)

(e) Date of Diagnosis : _____
(dd/mm/yyyy)

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

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

(h) Was the condition a result of an accident? Yes No
If **Yes**, please state date of accident : _____

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

(2024.03)



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

(k) Last occupation before disability occurred : _____

(l) Nature of duties of last occupation : _____

(m) Is the patient currently working? Yes No
If Yes, what is the occupation? _____

(n) 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 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 :

(i) Is the patient mentally incapacitated in accordance to the Mental Capacity Act 2008 (2020 Revised Edition)? Yes No

Hospital / Clinic Stamp

Date (dd/mm/yyyy) _____

Signature of Attending Doctor

Name and Address

Qualification

(2024.03)



(j) 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)

(k) 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?

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

(m) 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)	Source of Information	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 :

Please provide the Name of Address of the referring doctor and attach a copy of the referral letter:

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

Hospital / Clinic Stamp

Date (dd/mm/yyyy)

Signature of Attending Doctor

Name and Address
Qualification

(2024.03)



DECLARATION OF BENEFICIAL OWNERSHIP

Is there a beneficial owner in receiving this payment? Yes No

If Yes, please provide the particulars of the beneficial owner(s) to this policy and submit a copy of their NRIC / Passport (certified by your servicing adviser) to us.

Name(s) : _____

NRIC / Passport No(s) : _____

Address(es) : _____

Contact No(s) : _____ (H) _____ (O) _____ (HP)

Relationship to Deceased :

Nationality: Singaporean Singapore PR Others, please specify _____

Note:

Beneficial owner, in relation to a customer of a financial adviser, means the natural person who ultimately owns or controls a customer or the person on whose behalf a transaction is being conducted and includes the person who exercises ultimate effective control over body corporate or unincorporated.

Signature of Claimant

Date : _____
(dd/mm/yyyy)

Name(s) : _____

NRIC No(s) : _____

Address(es) : _____

Contact No(s) : _____ (HP)

Relationship : _____



CONSENT FORM FOR MEDICAL REPORT

NAME OF PATIENT : _____
NRIC NO. : _____ POLICY NO. : _____

This consent form is required for an insurance claim.

Authorization

I / We 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. ("Company"), any relevant information concerning the above-named patient, and;
- (b) the Company 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 / Guardian
Name : _____
Address : _____

NRIC No. : _____ Relationship to patient : _____

* If the patient is below 21 years old, this form should be signed by the patient's parent / guardian

(2024.03)



AUTHORISATION FORM FOR CREDITING TO SINGAPORE BANK ACCOUNT

Policy No	
Type of Payment	Claims

Please select ONE option:

<input type="checkbox"/>	PayNow registered with Singapore NRIC/FIN <ul style="list-style-type: none">• Please note that PayNow account registered with mobile number is not accepted.• You may register for PayNow account using your Singapore NRIC/FIN via “Manage Paynow” in your internet banking or mobile banking application.• If the PayNow transaction is unsuccessful, we will send you a cheque to your mailing address.						
<input type="checkbox"/>	Electronic Fund Transfer to your Singapore Bank Account <ul style="list-style-type: none">• Please attach a copy of your bank statement/passbook showing your name and bank account no. We accept bank statements with balance/transactions masked. Truncated e-statements downloaded from banks’ mobile application are also acceptable as long as the document shows the account holder’s name and account number on the same page.						
<table border="1"><tr><td>Name of Singapore Bank</td><td></td></tr><tr><td>Account No</td><td></td></tr><tr><td>Bank Account Holder’s Name</td><td></td></tr></table>		Name of Singapore Bank		Account No		Bank Account Holder’s Name	
Name of Singapore Bank							
Account No							
Bank Account Holder’s Name							

Declaration & Authorisation

I/We Hereby Authorise Tokio Marine Life Insurance Singapore Ltd to Credit The Amounts Due To Me/Us To The Above Requested Paynow/Bank Account, Where Applicable. Amounts so credited would constitute valid discharge of above payment due to me/us.

I/We understand and agree that:

- Where I/we are eligible to receive payments from Tokio Marine Life Singapore Ltd (“TMLS”) for policy proceeds (“Payment”) as determined by TMLS, the Payment will either be credited to my/our bank account linked to my/our Singapore NRIC/FIN, which I/we have registered with a bank for PayNow or bank transfer (depending on option chosen above). For avoidance of doubt, Payment is not applicable to PayNow linked to your mobile or company UEN.
- By completing this form, I/we declare it is my/our responsibility to ensure that all information submitted herein is correct and complete to the best of my/our knowledge. TMLS is not obliged to ensure that all information provided by me/us herein is accurate or that it remains true and accurate at the time of processing the Payment.
- PayNow or the bank transfer service is not operated by TMLS and my/our access to and use of PayNow or for a bank transfer is subject to the availability of PayNow and their services and that of my/our bank for the bank transfer. TMLS does not warrant my/our use of PayNow or for a bank transfer and the use is subject to the relevant terms and conditions of PayNow and/or my/our bank.
- I/we shall indemnify TMLS against all costs, damages and/or losses arising from or in connection with any breach by me/us of these terms or the terms and conditions imposed by my/our bank in relation to a bank transfer, or PayNow, or their service provider, my/our bank.



- e) TMLS shall bear no liability to me/us or any other party in the event the Payment is not made into my/our bank account otherwise, or the Payment being late, unsuccessful, or incomplete, or the suspension, termination, or discontinuance of PayNow or their services.
- f) TMLS has the sole discretion to make Payment using any other method as it deems fit and TMLS shall be entitled to terminate or suspend the Payment of your policy proceeds to me/us, and/or to add to, delete, or change the terms herein at any time without notice, without liability to me/us.
- g) TMLS shall not be deemed to provide cover and neither should TMLS be liable to pay any claim, provide any benefit under the Policy/relevant Policy or be required to process any request made to the extent that the provision of such cover, payment of such claim, provision of such benefit or processing of such request would expose TMLS (or its parent company or holding company (in both instances, whether direct or indirect) or the subsidiaries of its parent or holding company) to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the applicable jurisdiction, Singapore, the European Union, United Kingdom or United States of America.
- h) Where TMLS becomes aware that I/We, the Life Assured or any person or entity connected with the Policy/relevant Policy (see paragraph below) is/are subject to any sanction, prohibition or restriction under such resolutions, trade or economic sanctions, laws or regulations mentioned in the paragraph above, TMLS shall be entitled to block, suspend and/or terminate the Policy/relevant Policy at any time including but not limited to, not making or receiving any payments under the Policy/relevant Policy. The decision of TMLS on the aforementioned is final.
- i) A person or entity connected with the Policy/relevant Policy includes an assignee, a beneficiary, a trustee, an executor, an administrator, a director or direct/indirect shareholder or person having executive authority or natural persons appointed to act on my/our behalf, for my/our beneficial owners or beneficiaries' beneficial owners. As an ongoing obligation, I/We will immediately inform TMLS if there are any changes to the identities, status/ constitution/ establishment, particulars, and identification documents of these persons.
- j) A person who is not a party to this agreement shall have no right under the Contracts (Rights of Third Parties) Act 2001 to enforce any of these terms.
- k) These terms shall be governed by the laws of Singapore and the exclusive jurisdiction of the Courts of Singapore.

Personal Data Notice

I / We agree and consent that Tokio Marine Life Insurance Singapore Ltd. 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 the Tokio Marine Insurance Group's Data Protection Policy available www.tokiomarine.com which I / we have read, understood and agreed to the same.

Signature of Assured	Date
Name: _____	NRIC No: _____
Email: _____	Mobile No: _____