SINGAPORE LIFE LTD
Group Life & Health Claims
4 Shenton Way, #01-01 SGX Centre 2
Singapore 068807
Tel: 6827 8030
Company Registration No. 196900499K

PUBLIC OFFICERS GROUP INSURANCE SCHEME (POGIS) – CLAIMS PROCEDURE AT A GLANCE

Please refer to the following documents required for filing each type of claim:

A. For Death Claim

1) Death Claim Form (to be completed)
2) Certified True Copy of Death Certificate
3) Certified True Copy of Marriage Certificate if deceased was married
4) Certified True Copy of deceased's Birth Certificate and copy of deceased's parents' identity cards if deceased was not married
5) Certified True Copy of Claimant's identity card (front and back)
6) Certified True Copy of Last Intestate Will (if any)

Note: Singlife will request for the Physician Statement if there is insuffient information on the submitted documents.

Please submit the following additional documents if death cause is due to accidental events:

1) Police Investigation Report
2) Post Mortem / Autopsy Report
3) Toxicology Report
4) Coroner's Inquest

B. For Total & Permanent Disability / Partial & Permanent Disability / Terminal Illness Claim

1) Total & Permanent Disability / Partial & Permanent Disability / Terminal Illness Claim Form (to be completed)
2) Physician's Statement (to be completed by Attending Physician)
3) Certified True Copy of all X-ray / Laboratory tests / MRI / CT Scan Reports
4) Certified True Copy of Member's NRIC (front and back)

Note: Cost of the Physician's Statement and/or medical evidence shall be borne by the Member.

C. For Critical Illness / Early Critical Illness Claim

1) Critical Illness / Early Critical Illness Claim Form (to be completed)
2) Physician's Statement (to be completed by Attending Physician)
3) Certified True Copy of all X-ray / Laboratory tests / MRI / CT Scan Reports
4) Certified True Copy of Member's NRIC (front and back)

Note: Cost of the Physician's Statement and/or medical evidence shall be borne by the Member.

IMPORTANT NOTE:

- **The above are the basic documents required for filing the claim, any other additional documents required will depend on the case itself. We reserve the right to pursue for the said documents.**

Submission of claim documents:

Contact us at 6827 8030 to guide you through the claim process or email the complete set of claim documents to pogis_claims@singlife.com (Note: This is applicable for claim event occurring in Singapore only).

Alternatively, please submit the complete set of claim documents to our Customer Service Counters or mail in to us at:

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Attention: POGIS Claims Team

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TOTAL & PERMANENT DISABILITY / PARTIAL & PERMANENT DISABILITY / TERMINAL ILLNESS CLAIM FORM

IMPORTANT:

1. Please refer to the **Claims Procedure at a Glance** for documents required for submission of this claim.
2. Member will be responsible for the accuracy and integrity of the information provided. Failure to provide details or disclose all relevant information may delay the claim assessment.
3. Member shall bear the cost of medical reports (if any).
4. Please continue to pay the premiums until we have informed you on the outcome of the claim.
5. Singapore Life Ltd does not admit liability by the mere issue of this or any other form.

SECTION 1 – To be completed by Member

Type of Claim (please √ box)	❒ Total & Permanent Disability	❒ Partial & Permanent Disability	
	❒ Terminall Illness		
A. Details of Member			
Name of Member			
NRIC/FIN/Passport/BC No.	Date of Birth	Gender	Marital Status
Mailing Address			Contact No.
Email			
B. Details of Disability/Illness			
1) Date the Member FIRST consulted doctor for the condition (dd/mm/yyyy)	2) a) Symptoms presented	b) Date symptoms FIRST started	
3) Name of doctor and address of hospital/clinic			
4) Exact diagnosis	5) Date of FIRST diagnosis		
6) Has the Member previously suffered from or received treatment for a similar or related Disability/Illness? If "Yes", please provide full details.			❒ Yes ❒ No
7) Is the Disability/Illness a result of an Accident? If "No", please proceed to Question 8. If "Yes", please provide details as follows:			❒ Yes ❒ No
a) Date & Time of Accident:	b) Place of Accident:		
c) Describe in detail how the accident happened.			
d) Describe the nature and extent of injuries/disability sustained, including exact site(s) of the body.			
e) Was the accident reported to the Police? If "Yes", please provide a copy of the police investigation report.			❒ Yes ❒ No
8) Date the Member Last worked (dd/mm/yyyy):	9) Is the Member currently confined to ❒ Bed ❒ House ❒ Hospital ❒ Others:___________		

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B. Details of Disability/Illness (continue)

10) Date the Member Returned to work (dd/mm/yyyy):	11) Date confinement started (dd/mm/yyyy):

12) If the Member has not returned to work, date he/she is expected to return to work (dd/mm/yyyy).

13) Details of doctor(s) consultation and/or hospital(s) admission for **THIS** Disability/Illness

Name of doctor & Address of hospital/clinic	Date First & Last Consultation (dd/mm/yyyy)	Treatment Provided

14) Has the Member been hospitalized for condition(s) **RELATED** to **THIS** Disability / Illness? ❒ Yes ❒ No
If "Yes", please state:

Name of doctor & Address of hospital/clinic	Date of Admission & Discharge (dd/mm/yyyy)	Reasons for Hospitalisation	Treatment Provided

15) Details of Member's doctor(s) consultation for any **OTHER** disorders / conditions

Name of doctor & Address of hospital/clinic	Date First & Last Consultation (dd/mm/yyyy)	Reasons for Consultation	Treatment Provided

16) Is the Member claiming from any other Insurer(s) or other sources in respect of **THIS** Disability / Illness? ❒ Yes ❒ No
If "Yes", please provide the details.

Name of Insurer	Type of Plan	Policy Effective Date	Sum Assured

C. Daily Activities Before and After Disability/Illness

1) List the daily activities the Member engaged **Before** this Disability/Illness.

2) List the daily activities the Member engages **After** this Disability/Illness.

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3) Please elaborate what is preventing the Member from doing the daily activities he/she used to engage before this Disability/Illness.

D. Details of Member's Occupation (just before the Disability/Illness)			
1) Occupation (Title and Job Duties)			
2) Name & Address of Employer			
3) Employment Status	❒ Full-Time ❒ Part-Time ❒ Contract ❒ Temporary ❒ Unemployed		
4) Date of Employment		5) Date Last Worked	
6) Date this Disability has totally and permanently prevented the Insured Person from performing the material duties of his/her occupation (dd/mm/yyyy).			

E. DECLARATION AND AUTHORISATION

I/We consent to Singapore Life Ltd. ("Singlife") (and Singlife related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy (ies), account(s) and/or managing my/our relationship with Singlife.

I/We also consent to Singlife (and Singlife related group of companies) disclosing and transferring my/our personal data to Singlife (and Singlife related group of companies) and their respective third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

On behalf of myself and all proposed insured lives, I/we consent to Singlife disclosing and transferring my/our personal data to a new insurer selected by POGIS for the purpose of facilitating and/or administering insurance coverage with the new insurer.

I/We have read and understood Singlife's Data Protection Notice which may be found at www.singlife.com/pdpa. Singlife's Data Protection Notice may be updated from time to time without notice. I/We am/are aware that I/we should visit your website regularly to ensure that I/we am/are well informed of the updates.

Name and signature/thumbprint of Insured Employee	NRIC/Passport number	Date (dd/mm/yyyy)
Name and signature/thumbprint of Member who is 21 years old or above (if different from Insured Employee)	NRIC/Passport number	Date (dd/mm/yyyy)

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F. To be completed by the relevant Ministry / Statutory Board's Authorised HR Officer only

Name of Insured Employee	NRIC / Passport No:
Name of company	Date of Employment (dd/mm/yyyy)
Name of Authorised Officer	Contact Number/ Email address of Authorised Officer
Signature & Company Stamp	Date (dd/mm/yyyy)