



**Aviva Life Insurance Company Limited**

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**TEMPORARY DISABILITY INSURANCE CLAIM – CLAIMANT’S STATEMENT**

**POLICY NUMBER:** \_\_\_\_\_

IMPORTANT NOTE : Please answer all the following question fully. Failure to provide details or to disclose all relevant matter may delay claim assessment.

<b>1. PERSONAL PARTICULARS</b>		
Name of Life Assured	HKID / Passport No.	Date of Birth
Sex	Marital Status	Occupation
Home Address		
Tel (Office)	Tel (Home)	Tel (Mobile)

**2. DETAILS OF DISABILITY**

1. Describe fully the nature of disability and the cause thereof. If accidental injury(ies), please describe the full details of how the accident occurred. If it is due to sickness, please provide details of when the symptoms or conditions is noted or detected.

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2. Have you previously suffered from disability of this nature?

YES  NO

If "Yes", please elaborate:

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3. When did your illness/ accident first begin or happen? Date : ..... (dd/mm/yy)

4. When did you become totally disabled so as to be prevented from doing any work?

Date : ..... (dd/mm/yy)

5. State briefly your present daily activities:

.....  
.....  
.....

6. Are you currently seeing any physician in connection with this disability: YES NO

If "Yes", please elaborate :

<u>Name of Physician</u>	<u>Address</u>	<u>Date of Treatments</u>	<u>Type of Treatments</u>
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.....	.....	.....	.....
.....	.....	.....	.....

7. Please describe the duties of your occupation (including any physical work involvement, if any) just BEFORE the disability.

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8. Please state the name of all the physicians and addresses of the clinic or hospital that you have consulted for the past 2 years.

<u>Name of Physician</u>	<u>Address of Clinic / Hospital</u>	<u>Purpose of Consultation / Operation</u>
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.....	.....	.....
.....	.....	.....

9. Are you following any occupation(s) on either full-time or part-time basis since first becoming disabled?  YES  NO

If "Yes", please advise:

a) Nature of occupation

.....  
.....

b) Salary per month ..... Date employment commenced .....

c) Company Name .....

d) Company Address .....

If "No", please advise:

a) Reason .....

b) Date you expect to be able to return to work: ..... (dd/mm/yy)

10. Are you receiving benefit from other source ?

YES     NO

If "Yes", please advise: a) Source : .....  
b) Amount : .....

11. Are you now receiving any income or claiming under any policy?

YES     NO

If "Yes", please furnish details : HK\$ ..... Per month  
Name of Payor : .....

**Declaration & Authorisation:**

I, ..... (HKID / Passport No.....) declare that the answers given by me in this Form are in every respect true and correct and that no material information has been withheld nor any relevant circumstances omitted.

I further consent to **Aviva Life Insurance Company Limited** seeking information from any clinic, hospital, physician, person, organisation, employer that may be required in connection with this claim and I authorise the giving of such information to Aviva Life Insurance Company Limited. A photocopy of this authorisation shall be considered as effective and valid as the original.

Signature of Witness	:	_____	Signature of Claimant	:	_____
Name of Witness	:	_____	Name of Claimant	:	_____
HKID / Passport No.	:	_____	HKID / Passport No.	:	_____
Address	:	_____	Address	:	_____
	:	_____		:	_____
Date	:	_____	Date	:	_____