AVIVA LTD
Group Life & Health Claims
4 Shenton Way, #01-01 SGX Centre 2
Singapore 068807
Tel: 6827 8030 Fax: (65) 6827 7705
Company Registration No. 196900499K

CONNECTEDLIFE GROUP INSURANCE – CLAIMS PROCEDURE AT A GLANCE

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

For Hospital Recuperation Benefit under Group Personal Accident policy:

1) Hospital Recuperation Benefit Claim Form (to be completed)
2) Copy of finalized hospital bill (admission and discharge dates have to be indicated)
3) Copy of Inpatient Discharge Summary / Doctor's memorandum indicating diagnosis and date of injury

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.**
- **For submission via email, please ensure that documents are colored scanned.**

Submission of claim documents:

To submit a claim, complete the relevant Claim Form and also have on-hand the required supporting documents. Thereafter, email us the complete set of claim documents for our claim review. We will acknowledge your electronic claim submission within 2 business days.

Alternatively, you may call us and we will be able to guide you through the claim process.

You may contact us at:

Claims Hotline – 6827 8030

Our Operating Hours:
Mondays – Fridays 8.45am – 5.30pm
Closed on Saturdays, Sundays and Public Holidays

Email Address – Managed_Care3@aviva-asia.com

ConnectedLife Claims Hotline – 9145 1576

Email Address – customer@connectedlife.io

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CONNECTEDLIFE GROUP INSURANCE
HOSPITAL RECUPERATION BENEFIT CLAIM FORM

IMPORTANT:

1. Please refer to the **Claims Procedure at a Glance** for documents required for submission of this claim.
2. The Insured Person/Insured 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. The Insured Person/Insured Member shall bear the cost of medical reports fees (if any).
4. Aviva Ltd does not admit liability by the mere issue of this or any other form.

To be completed by the Insured Person

A. Details of Insured Person

Name of Insured Person			NRIC/FIN/Passport/BC No
Date of Birth	Gender	Mailing Address	
Email			Contact No.
Bank Name:	Branch:	Bank A/C No.:	

B. Details of Accident

Date of Accident (dd/mm/yyyy)	Place of Accident
Description of Accident & Nature of Injury	

C. Declaration And Authorisation

I/We declare that the answers given by me/us in this form are in every respect true and correct and that no material information has been withheld or any relevant circumstance omitted.

I/We declare that I/we am/are not an undischarged bankrupt and there is no actual or pending bankruptcy proceeding against me/us and I/we have not assigned the Policy to any other party.

I/We consent to Aviva Ltd and Aviva related group of companies:

i) seeking information from any clinic, hospital, physician, person, organization, employer that may be required in connection with this claim and I/we authorize the giving of such information to Aviva. A photocopy of this authorization shall be considered as effective and valid as the original.

ii) 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 Aviva.

iii) transferring my/our personal data to Aviva related group of companies and/or third party service providers, reinsurers, suppliers or intermediaries whether located in Singapore or elsewhere, for the above purposes.

Note to members:

- For full details of the purposes of collection, use and disclosure of your personal data, please visit http://www.aviva.com.sg/pdpa.html.
- If you are filling up this form on behalf of another person or whereby you are disclosing personal data to us other than yours, you are required to inform such person(s) of the purpose and obtain his/her consent before submitting this form to us. Once you have submitted, you will be deemed to have obtained the necessary consent for us.

Name & Signature of Insured Member

Date (dd/mm/yyyy)