TOTAL AND PERMANENT DISABILITY CLAIM

Dear Policy Owner,

We are sorry to learn of our Insured's medical condition. To assist us in processing the claim, please submit the following:

Documents Required

1. Duly completed Total and Permanent Disability Claim Form
2. Duly completed Doctor's Statement
3. All available laboratory, hospital reports & test results
4. Police investigation report and newspaper clipping (if due to accidental or unnatural causes)
5. Copy of NRIC or identity documents (e.g. passport, birth certificate) of Life Insured, Policy Owner and Beneficial Owner
6. Proof of relationship for 3rd party policies
7. Copy of Policy Owner's bank passbook / statement with name and account number
   (if you opt for direct fund transfer to a Singapore bank account)

If policy owner is a Corporate Entity

8. Copy of ACRA search report within the past 6 months/Certificate of Incorporation
9. Entity Tax Residency Self-certification form
10. Controlling Person Tax Residency Self-certification form (if applicable)
11. Copy of NRIC or identity documents of person who is signing on behalf of the company

Notes

1. This form is to be completed by the Policy Owner and signed using the same signature as our record.
2. All sections of the form must be duly completed. Please indicate as "N.A." if not applicable.
3. All non-English documents must be officially translated into English by a certified translator.
4. All overseas documents need to be authenticated by a Notary Public of the country where documents were issued. Please note that the original documents have to be produced for verification.
5. The Doctor's Statement must be completed by the doctor who attended to the insured's condition. All fees for completion of the Statement and/or medical reports shall be borne by the Policy Owner.
6. Proof of Relationship can be Marriage Certificate, Birth Certificate etc.
7. Please continue to pay the premiums due during the period when we are still processing the claim.
8. We reserve the right to sight the original documents and/or request for additional documents / information to assess the claim.

Submission of documents

All claim documents may be submitted in the following ways:

1. Visit our Customer Service Centre at:
   3 Anson Road, #18-00, Springleaf Tower
   Singapore 079909
   Operating hours: 8.45am - 5.30pm, Mon-Fri

2. Postal mail to:
   China Taiping Insurance (Singapore) Pte Ltd
   3 Anson Road, #16-00, Springleaf Tower
   Singapore 079909
   Attention: Life Insurance Claims

3. Contact the servicing Financial Adviser Representative to assist you

4. Email us at: customer.service@sg.cntaiping.com

CTPIS/LIFE/CLM-TPD/082025

TOTAL AND PERMANENT DISABILITY CLAIM FORM

1. POLICY INFORMATION

Please list all policy numbers on which you are filing this claim

2. PARTICULARS OF POLICY OWNER

Name (as shown in NRIC / Passport)		NRIC / Passport Number
Residential Address	Contact Number	Email Address

3. PARTICULARS OF LIFE INSURED (if different from Section 2)

Name (as shown in NRIC / Passport)	NRIC / Passport Number
Residential Address	

4. DETAILS OF OCCUPATION

	Before disability	After disability
i. Occupation		
ii. Employment status	☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Permanent Basis ☐ Contract Basis ☐ Temporary Basis ☐ Full-time ☐ Part-time	☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Permanent Basis ☐ Contract Basis ☐ Temporary Basis ☐ Full-time ☐ Part-time
iii. Exact occupational duties If Life Insured is not working before disability, please provide a list of the daily activities.		
iv. Name and Address of Business and Employer		
v. Last drawn Monthly Income	SGD	SGD
vi. Date Life Insured last worked	_____ / _____ / _____ (dd/mm/yyyy)	_____ / _____ / _____ (dd/mm/yyyy)

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5. DETAILS OF DISABILITY

i. If the Life Insured is issued with hospitalisation leave and/or medical leave, please provide the duration	Type of Leave	From (dd/mm/yyyy)	To (dd/mm/yyyy)
	Hospitalisation Leave		
	Medical Leave		
ii. Has the Life Insured returned to work?	☐ Yes, resume full duties ☐ Yes, light duties	Please provide date Life Insured return to work: _____ / _____ / _____ (dd/mm/yyyy)	
	☐ No	Please provide expected date of return (if any): _____ / _____ / _____ (dd/mm/yyyy)	
	☐ NA (for Unemployed)		
iii. Is the Life Insured currently confined to:	☐ Bed ☐ House ☐ Hospital ☐ Wheelchair ☐ None of above		

iv. Is the Life Insured able to perform, without assistance, following activities of daily living:

a)	Eating	☐ Yes	☐ No
b)	Walking	☐ Yes	☐ No
c)	Dressing	☐ Yes	☐ No
d)	Bathing	☐ Yes	☐ No
e)	Using toilet	☐ Yes	☐ No
f)	Getting in and out of Bed	☐ Yes	☐ No

v. Was the disability due to suicide, self-destruction or intentional self-inflicted injury? ☐ Yes ☐ No
If Yes, please provide details:

5a. DETAILS OF DISABILITY (due to accident)

i. Date of accident	____ / ____ / _____ (dd/mm/yyyy)	ii. Time of accident	AM / PM * *Delete where appropriate
iii. Place and Country of Accident			
iv. Describe in detail how the accident happened, nature and extent of injuries sustained			
v. Was a police investigation carried out?		☐ Yes ☐ No If Yes, please provide details below and a copy of the police report	
Name of Investigation Officer	Contact Number	Branch & Address of Police station	
vi. Was there any eye witness to the accident?		☐ Yes ☐ No If Yes, please provide details below and a copy of the police report	
Name of witness	Relationship with deceased	Address & Contact Number	

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5b. DETAILS OF DISABILITY (due to illness)

i. Describe fully the symptoms:

Symptoms presented	Date symptoms presented (dd/mm/yyyy)

ii. Date Life Insured first consulted a doctor	_____ / _____ / _____ (dd/mm/yyyy)
iii. Describe fully the diagnosis, underlying cause & extent of the illness	
iv. Diagnosis date	_____ / _____ / _____ (dd/mm/yyyy)
v. Has the Life Insured previously suffered or received treatment for similar illness/condition?	☐ Yes ☐ No If Yes, please provide details below

Illness/Condition	Diagnosis Date (dd/mm/yyyy)	Last consult date (dd/mm/yyyy)	Name & Address of treating doctor

6. RECORD OF MEDICAL CONSULTATION

i. Please provide details of all the doctors whom Life Insured has consulted in connection with the illness/injury:

Name of doctor	Name and Address of clinic / hospital	Date first consulted for the illness/injury (dd/mm/yyyy)

ii. Please provide the details of regular doctor(s) and company doctor(s) whom Life Insured has consulted for minor ailments (e.g. flu, cough, fever), high blood pressure, high cholesterol, diabetes etc.:

Name of doctor	Name and Address of clinic / hospital	Date of consultation (dd/mm/yyyy)	Reason(s) for consultation

7. OTHER INFORMATION

i. Does Life Insured have similar benefits with other insurance company?			☐ Yes ☐ No If Yes, please provide details below	
Name of Insurer	Type of Plan	Date of Issue	Sum Assured	Claim Notified

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7. OTHER INFORMATION (continued)

ii. Have you been bankrupt or insolvent or has executed any deed or transfer for the benefit of creditors since becoming interested in the policy?	☐ Yes ☐ No If Yes, please provide details below
Country that issued the bankrupt order	Year declared bankrupt
If discharged from bankruptcy, please provide letter of discharge from Official Assignee.	

8. DECLARATION OF OWNERSHIP

i. Is there a beneficial owner in receiving this payment? ☐ Yes ☐ No
If Yes, please provide details below

Name	NRIC / Passport Number	Nationality	Relationship to Policy Owner	Address & Contact Number

Note: Beneficial Owner, in relation to a customer of a financial adviser, means the natural person who ultimately owns or controls the customer or the natural person on whose behalf business relations are established, and includes any person who exercises ultimate effective control over a legal person or legal arrangement.

9. PAYMENT INSTRUCTION

These instructions will not supersede any instructions (if any) regarding the mode of payment on all your existing policy(ies) with us.

Please select only <u>**one**</u> option:

☐ PayNow (via NRIC/FIN proxy)

☐ - ☐☐☐☐☐☐☐ - ☐

- This NRIC/FIN proxy must belong to the Policy Owner.
- Only applicable for policies denominated in Singapore Dollars.
- You must register for PayNow using your NRIC/FIN no. as proxy to receive payment.

☐ Direct credit to designated bank account

Bank Account Number: ....

Name of Bank: ....

Bank branch code: ....

- This account must belong to the Policy Owner.
- Please <u>submit</u> a **copy of your bank book or recent bank statement** for account verification. (You need to circle the account for crediting if your statement shows more than 1 bank account)
- Only applicable for policies denominated in Singapore Dollars.
- Account must be a Singapore Dollars (SGD) bank account in Singapore.

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10. DECLARATION AND AUTHORISATION

1. I understand and agree that the submission of this form does not mean that the claim will be paid. I understand that any payout under the Policy shall be strictly in accordance with the Policy terms and conditions.
2. I hereby declare that the information that is disclosed on this form is to the best of my knowledge and belief, true, complete and accurate, and that no material information has been withheld or is any relevant circumstances omitted. I further acknowledge and accept that China Taiping Insurance (Singapore) Pte Ltd ("CTPIS") shall be at liberty to deny liability or recover amounts paid, whether wholly or partially, if any of the information disclosed on this form is incomplete, untrue or incorrect in any respect or if the Policy does not provide cover on which such claim is made.
3. I acknowledge and accept that the furnishing of this form, or any other forms supplemental thereto, by CTPIS, is neither an admission that there was any insurance in force on the life in question, nor an admission of liability nor a waiver of any of its rights and defenses.
4. I acknowledge and accept that CTPIS expressly reserves its rights to require or obtain further information and documentation as it deems necessary.
5. For the purposes of (i) assessing, processing and investigating my claim(s) arising under the Policy and such other purposes ancillary or related to the assessing, processing and investigating my claim(s) and administering of the Policy, (ii) customer servicing, statistical analysis, conducting customer due diligence, reporting to regulatory or supervisory authorities, auditing and recovery of any debts owing to CTPIS under this Policy, (iii) storage and retention, (iv) meeting requirements of prevailing internal policies of CTPIS, and as set out in the Privacy Notice ("Purpose"), I authorise, agree and consent to:
   a. Any person(s) or organisation(s) that has relevant information concerning the Policy Owner and the insured person(s) (including any medical practitioner, medical/healthcare provider, financial service providers, insurance offices, government authorities/regulators, statutory boards, employer, or investigative agencies) ("Person(s)/Organisation(s)") pertaining to this claim, to disclose, release, transfer and exchange any information to CTPIS , its officers, employees, representatives or distribution partners, including without limitation, all personal data, medical information, medical history, employment and financial information, including the taking of copies of such records; and
   b. CTPIS , its officers, employees, representatives or distribution partners collecting, using, disclosing, releasing, transferring and exchanging personal data about me, the Policy Owner and the insured person(s), with any person(s) or organisation(s) listed in above, CTPIS's related group of companies, third party service providers, insurers, reinsurers, suppliers, intermediaries, lawyers/law firms, other financial institutions, law enforcement authorities, dispute resolution centres, debt collection agencies, loss adjustors or other third parties assisting with my claim for the Purpose.
6. Where any personal data ("3rd Party Personal Data") relating to another person ("Individual") (including without limitation, insured persons, family members, and beneficiaries) is disclosed by me, I represent and warrant that I have obtained the consent of the Individual for CTPIS, its officers, employees, representatives or distribution partners to collect and use the 3rd Party Personal Data and to disclose the 3rd Party Personal Data to the persons enumerated above, whether in Singapore or elsewhere, for the Purpose stated above and in CTPIS Privacy Notice.
7. I agree to indemnify CTPIS for all losses and damages that CTPIS, its officers, employees, representatives or distribution partners may suffer in the event that I am in breach of any representation and warranty provided to me herein.
8. I agree to receive communication on the claim by email, SMS and/or hard copies by post.
9. I agree that (i) CTPIS shall have full access to the information stated in this form, and (ii) this authorisation and declaration shall form part of my proposed application for the relevant insurance benefits, and a photocopy of this form shall be treated as valid and binding as if it were the original.
10. I/We confirm that I/we have read and understood and hereby consent to the collection, use, processing and disclosure of my/our personal data in accordance with and agree to be bound by CTPIS Privacy Policy which is made available on our website at https://www.sg.cntaiping.com/en/privacypolicy, as may be amended from time to time.
11. I/We agree that CTPIS is authorized to collect, retain, use and/or disclose as it reasonably deems fit, any information in respect of me/us that is received by CTPIS to its representatives and relevant third parties, companies within China Taiping Insurance group, related corporations of CTPIS, reinsurers, medical organisations, my/our adviser, financial institutions, CPF agent banks, credit agencies, reinsurers, investigators, service providers (who may have to disclose my/our data to their service providers such as medical providers and medical evacuation agencies), judicial, regulatory, government, relevant authorities, professional advisers, auditors and consultants, whether within or outside Singapore. As far as reasonably possible, CTPIS will release such information to such parties on the understanding that the information will be kept strictly confidential and be used, disclosed and retained in accordance with relevant laws.

Signature of Policy owner *(with Company's Name and Stamp if Corporate policies)*	Date (dd/mm/yyyy) ____ / ____ / _____
Signature of Life Insured *(if different from Policy Owner & 16 years old or above)*	Date (dd/mm/yyyy) ____ / ____ / _____

If Policy Owner or Life Insured is unable to sign / does not have the mental capacity / is below 16 years old)

Signature of Claimant *(21 years old or above)*		Date (dd/mm/yyyy) ____ / ____ / _____
Name of Claimant	NRIC/Passport Number	Relationship to Policy Owner
Please indicate reason Policy Owner / Life insured is unable to sign		

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11. POLICY OWNER'S TAX RESIDENCY DECLARATION (FOR INDIVIDUAL)

For **Individual**, please complete **all sections** below.
For **Entities**, please complete a separate Entity Tax Residency Self-certification form

A. Common Reporting Standards (CRS) Tax Residency Self-Certification

WARNING: Singapore Income Tax Act 1947 imposes a penalty of a fine not exceeding $10,000 and / or imprisonment of up to 2 years, on individual that is known to provide false or misleading information. For more information, please refer to Section 105M of the Income Tax (Amendment No.2) Bill 2016.

i. Details of Tax Residency*

Please provide information on your Tax Residency (i.e. where you are liable to pay income taxes). If you have any questions on how to define your Tax Residency status, please visit http://www.oecd.org/tax/automatic-exchange/crs-implementation-and-assistance or speak to a professional tax adviser.

CRS Declaration of Tax Residency (Tick where applicable. You may select more than 1)*		
1. I am a tax resident of **Singapore** **Taxpayer Identification Number (TIN):** _____	☐	Please complete **Part iii**
2. I am a tax resident of other country(ies) / jurisdiction(s)	☐	Please complete both **Part ii & iii**

ii. Details of Foreign Tax Residency(ies)*

Please provide ALL the country(ies) (excluding Singapore) in which you are a tax resident and the associated Taxpayer Identification Number (TIN).

	Country/Jurisdiction of Tax Residency	Taxpayer Identification Number (TIN)	If you are unable to provide the TIN, Please tick one of the reasons*			If Reason B has been selected, please indicate why TIN is not available
1			☐ A	☐ B	☐ C	
2			☐ A	☐ B	☐ C	
3			☐ A	☐ B	☐ C	

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

Clarification of Tax Residency

If your declared country(ies)/jurisdiction(s) of tax residency does not include the country of your **residential/mailing address, contact number, country of birth, nationality or citizenship**, please provide the reason below**.**

_____

_____

iii. Acknowledgement of Tax Residency*

☐ I confirm that I am not a tax resident of any country(ies) other than the one(s) that I have declared above. I shall notify CTPIS within 30 days from date of change.

B. Declaration on U.S Status

☐ I am not a U.S. Person / Person with U.S. Indicia and I am not acting for / on behalf of a U.S Person / Person with U.S Indicia. If my tax status changes and I become a U.S Person / Person with U.S Indicia. I shall notify CTPIS within 30 days from date of change.

☐ I am a U.S. Person / Person with U.S. Indicia (please delete accordingly) and I have submitted the Declaration for U.S Person and U.S Indicia Form.

Please specify Tax Payor Identification No. (TIN) ☐☐☐ - ☐☐ - ☐☐☐☐

♦ For definition of U.S Person under/or U.S Indicia, please visit https://www.irs.gov
Please note that Form W-9 / Form W-8BEN need to be completed for U.S Person or Person with U.S Indicia respectively.

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C. Declaration and Authorisation

1. I declare that all information provided in this form are, to the best of my knowledge and belief, correct and complete.
2. I acknowledge and understand that the information contained in this self-certification and any reportable account(s) may be reported to the tax authorities of the country/jurisdiction in which this account(s) is/are maintained and exchanged with tax authorities of another country/jurisdiction or countries/jurisdictions in which I may be tax resident pursuant to intergovernmental agreements to exchange financial account information.
3. I agree to notify China Taiping (Singapore) Pte. Ltd. within 30 days of any errors, omissions or changes in the information provided in this form.

Name of Signatory (as shown in NRIC / Passport)	
Signature	Date (dd/mm/yyyy) ____ / ____ / _____

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