

Critical Illness Benefit Claim Form

This form must be duly completed and returned with 2 clinical abstract application forms.
The Company reserves the rights to require or to obtain further information should it deemed necessary.

Part 1 (To be completed by claimant)

A. Claimant's particulars				
Name of policyholder (Employer)		Policy no.	Membership no.	Date of employment
Name of employee		NRIC / Passport No.	Date of birth	Sex [] F [] M
B. Nature of claim and related details				
1. Name the critical illness you are claiming for?				
2. Describe fully the extent and nature of your current illness.				
3. On what date did you first consult a medical practitioner in connection with your illness?				
4. Have you previously suffered from, or received treatment for, a similar or related illness? If 'yes' give full details.				
C. Record of medical consultation/hospitalisation				
1. Please give below the details of any doctors or specialists who have been consulted in connection with your illness :				
<u>Date of consultation</u>		<u>Name of doctor(s)</u>		<u>Address(es)</u>
2. Please provide the name and address of your usual medical attendant if different from above.				
D General				
1. Have any of your blood relatives suffered from a similar or related illness? If 'yes', state: relationship of relative, nature of illness and the date when the illness was first diagnosed.				
2. Do you smoke cigarettes? If 'yes', state your daily consumption and how long have you been smoking? If no, have you ever smoked? If so, what was your daily consumption and when did you stop smoking?				
3. Are you insured for similar benefits with any other or related illness? If 'yes', state the name of the insurer, the amount of benefits insured and whether or not you have submitted a claim in connection with such insured benefits.				
<u>Name of company</u>		<u>Amount of benefits</u>		
Declaration and authorisation				
I hereby declare that the statements and answers given above are true and complete to the best of my knowledge and belief and that I have not made any false or fraudulent statement, any suppression and concealment of facts. I hereby authorise any hospital, doctor or other person who has attended to me or examined me for any reason, to disclose to HSBC Insurance (Singapore) Pte. Limited any and all information with respect to any illness or injury and, to provide HSBC Insurance (Singapore) Pte. Limited copies of all hospital or medical records, including prior medical history. A photostat copy of this authorisation shall be considered as effective and valid as the original.				
_____ Employer's signature/company's stamp/date			_____ Claimant's/employee's signature/date	