HSBC Insurance

# Group Total of Permanent Disability Claim Form

**Instructions:**

Please notify and provide proof of claim within 90 days from the date Total & Permanent Disability is certified and confirmed by a Medical Practitioner:

(1) Duly completed and signed claim form (Part 1 only).
(2) Medical Report from attending doctor (Part II) **
(3) Copy of Birth Certificate / Passport / Identity Card of the Insured Member (certified to be a true copy by an authorised senior officer of the Policyholder).
(4) Pay slip in the month of diagnosis (certified to be a true copy by an authorised senior officer of the Policyholder).
(5) All supporting laboratory and test results.
(6) A copy of the police report if Total & Permanent Disability occurs due to an accident

** Please furnish us with an updated medical report after six months from the date of disability.

Note: We reserve the right to request for any additional or original documents.

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**Part I** **Total & Permanent Disability Claim Form**

## A. Claimant's particulars

| Policyholder (Employer) | | | | Policy No. | Membership No. | |
|---|---|---|---|---|---|---|
| Insured Member (Employee) | Date of Birth | Sex<br>□ Female<br>□ Male | NRIC/Passport No./BC No | Occupation | Date of Employment | Sum Insured |
| Insured Dependant (if applicable) | Date of Birth | Relationship<br>□ Spouse<br>□ Child | NRIC/Passport No./BC No | Occupation | Effective date of Insurance | Sum Insured |

## B. Details of occupation and benefits

| | Before disability | After disability |
|---|---|---|
| (1) Occupation | | |
| (2) Name of employer | | |
| (3) Average monthly income | | |
| (4) Date salary was last adjusted | | |
| (5) List exact duties performed at work | | |

## C. Details of disability

| | |
|---|---|
| (1) Is the disability suffered due to : | □ Illness - Date symptoms first started:<br>□ Accident - Date/Time/Description of accident: |
| (2) Describe in details all symptoms and /or nature of injuries / disabilities suffered. | |
| (3) Date last actively at work | Date : |
| (4) Are you currently confined to your bed or house? | □ Yes □ No |
| (5) If Yes, please provide details | |
| (6) If No, please provide date you return to work | Date : |

## Details of Doctor(s) or Hospital(s) in connection for this disability

| **Name of Hospital / Clinic / Doctor and address** | **Dates treated** |
|---|---|
| | |

## Details of your regular doctor or any other doctor(s) consulted for any other disorders in the past 3 years

| **Name of Hospital / Clinic / Doctor and address** | **Reasons for consultation** |
|---|---|
| | |

**Declaration and authorisation**

We hereby declare that the above information provided above are true and correct in every aspect and that no material information have been withheld nor any relevant circumstances omitted. We agree and authorise to the release of any information to HSBC Insurance (Singapore) Pte Ltd in connection with this claim. A photocopy of this authorisation is as valid as the original.

Employer's signature / Company's stamp

Name :

Designation :

Signature of Employee /& Covered Dependant

Name :

NRIC No. :

Date :

**Part II – Medical Report by Attending Medical Doctor** (To be completed by doctor at Policyholder's Expense)

| Patient Name | NRIC / Passport No / BC No |
|---|---|
| Policyholder (The Employer) | Policy Number |
| 1. Are you the patient's regular medical doctor? If 'yes' over what period do your records extend? | |
| 2. Diagnosis (Describe the nature and severity of the disability) | |
| 3. When were you first consulted for this disease and, how long had symptoms been present? | |
| 4. Date of diagnosis of disability : | |
| 5 Was the diagnosis made know to the patient?<br>a. [ ] If 'yes', when was the date patient first made aware? | |
| b. [ ] If 'no', reason for not disclosing the diagnosis to patient. | |
| 6. Date of last consultation / examination | |
| 7. Date when first absent from work | |
| 8. To what extent does his disability prevent him from performing all normal duties of his usual occupation | |
| 9. If he is unable to return to his usual occupation, can he engage in any other type of occupation? | |
| 10. Describe treatment, including any operations performed. | |

11. Has patient been treated previously for the same illness / injury (ies) or any related condition? If 'yes', please state:

| Name Of hospital/Clinic/Doctor and address | Date treated |
|---|---|
| | |

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| 12. Provide the name of any hospitals / clinics to which the patient had been referred together with the names of the doctor(s) who had attended to the patient. | | |
|---|---|---|
| Name Of hospital / Clinic and address | Name of doctor(s) | Date referred |
| | | |

| | | |
|---|---|---|
| 13. | Is the patient suffering from any other conditions? If yes, does this have effect on the condition above? | |
| 14. | If there is any further information which, in your opinion, will assist us in assessing this claim, please furnish such information here. | |

15. In your opinion, does the patient fulfil the Total & Permanent Disability's definition stated below?

□ **Yes** □ **No**

**Definition of Total & Permanent Disability:**

This is defined as a disability caused by an accident or an illness, which is TOTAL, CONTINUOUS AND PERMANENT. It must result in a COMPLETE INABILITY to work in any occupation to earn an income for at least 6 continuous months after the start of the disability.

I hereby declare that the foregoing answers are each and all true to the best of my knowledge and belief.

Name : ______________________________ Signature : ______________________________

Professional Qualification : ______________________________ Date : ______________________________

Address : ____________________________________________________________

Issued by **HSBC Insurance (Singapore) Pte. Limited.** (Reg. No. 195400150N)
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