

HSBC Insurance (Singapore) Pte. Limited

10 Eunos Road 8, #11-01 Singapore Post Centre (South Lobby), Singapore 408600

Tel: (65) 6225 6111 Fax: (65) 6424 4156

Web: www.insurance.hsbc.com.sg

Company registration no. 195400150N

LivingSurance Claim Form

IMPORTANT NOTES

- This form is for claims submission under a LivingSurance policy. The issue of this form is not an admission of liability on the part of our company.
- Please read the instructions in this claim form carefully. You must complete Parts 1 and 3 and the relevant sections in Part 2.
- For questions marked with "*" please tick (✓) the box which is applicable to you. If the space provided is not sufficient, please provide the requested information on a separate sheet and attach it to the claim form when you submit it to us.
- You will need to provide all supporting documents to your claim with this form. Guidance as to what documents are required is available at the relevant section of this form. If any supporting document is in a language other than English, you are required to provide an English translation at your own expense.
- We may request further particulars/supporting documents at any time before your claim is finally assessed. We may also ask you to provide us with the original receipts, reports or any other documents submitted to us.
- For any claim involving "death" of the insured person, please also complete the "Proof of Death – Statement of Beneficiary" and provide us with a copy of the Death Certificate.
- You may post or fax or scan the completed claim form and all supporting documents to us. You are advised to retain a copy of all documents you submit to us for your own record.
- We will not pay any claim if you make a claim knowing any part of it to be false or exaggerated in any way. In such an event, we are also obliged by law to make a report to the relevant authorities.
- "We", "us" and "our" means HSBC Insurance (Singapore) Pte. Limited

PART 1

Details of Policyholder & Policy

Name of Policyholder:	NRIC No.:
Date of Birth:	Occupation:
Address:	Contact Nos.
	Home:
	Mobile:
	Office:
	Email:
Policy No.:	Policy Expiry Date:

Details of Claimant (if different from Policyholder)

Name of Claimant:	NRIC No.:
Date of Birth:	Occupation:
Address:	Contact Nos.
	Home:
	Mobile:
	Office:
	Email:

PART 2

Section A. Details of Injury / Illness

* Which critical illness (please refer to the Policy for full description) are you claiming for?

- | | |
|---|--|
| <input type="checkbox"/> Alzheimer Disease / Severe Dementia | <input type="checkbox"/> Kidney Failure |
| <input type="checkbox"/> Apallic Syndrome | <input type="checkbox"/> Loss of Speech |
| <input type="checkbox"/> Aplastic Anaemia | <input type="checkbox"/> Major Burns |
| <input type="checkbox"/> Baterial Meningitis | <input type="checkbox"/> Major Cancers |
| <input type="checkbox"/> Benign Brain Tumour | <input type="checkbox"/> Major Head Trauma |
| <input type="checkbox"/> Blindness (Loss of Sight) | <input type="checkbox"/> Major Organ / Bone Marrow Transplantation |
| <input type="checkbox"/> Coma | <input type="checkbox"/> Motor Neurone Disease |
| <input type="checkbox"/> Coronary Artery By-pass Surgery | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Deafness (Loss of Hearing) | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Paralysis (Loss of Use of Limbs) |
| <input type="checkbox"/> End Stage Liver Failure | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> End Stage Lung Disease | <input type="checkbox"/> Primary Pulmonary Hypertension |
| <input type="checkbox"/> Fulminant Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Surgery to Aorta |
| <input type="checkbox"/> Heart Valve Surgery | |
| <input type="checkbox"/> HIV Acquired Occupationally /Through Blood Transfusion | |

For condition involving injury, please describe the circumstances of accident leading to the injury:

Please provide details of all medical practitioner consulted on the critical illness and dates of consultations:

1. Name(s) and address(es):

2. Date of first consultation / treatment:

Date (DD/MM/YYYY)

3. Date of last consultation / treatment:

Date (DD/MM/YYYY)

What was the date of first diagnosis of the critical illness?

Date (DD/MM/YYYY)

If the insured person was admitted to hospital for the critical illness, please state:

Name and address of hospital:

Date of admission:

Time:

am/pm

Date of discharge:

Time:

am/pm

Please provide details of diagnosis and treatment received for the critical illness (Please attach all medical report(s) from the medical practitioner):

I hereby authorise the release of any of my personal medical information in relation to this claim by any medical professional or institution to HSBC Insurance (Singapore) Pte. Limited. A photocopy of this authorisation shall be considered as effective and valid as the original.

NAME:

SIGNATURE:

DATE:

[Empty box for Name]

[Empty box for Signature]

[Empty box for Date, with slashes for day/month/year]

Please provide us with all of the following documents relating to your claim:

- The medical report/hospital records giving full details of the matter for which treatment was sought (please use the "Attending Physician's Statement" Form)
- Any police report filed in relation to the accident leading to the injury
- Documents relating to any trip made overseas by the insured person in which the illness or injury was suffered or sustained

PART 3

DECLARATION

*Are you claiming insurance or compensation from any other insurance policies (including Work Injury Compensation, Motor Insurance, etc)?

- No Yes

If "Yes", please provide details below (e.g. policy number, type of cover and name of the insurance company):

*Have you ever made any previous claim in respect of injury or illness from any insurance company?

- No Yes

If "Yes", please provide the following:

1. Policy number:

2. Date of claim:

3. Claim amount:

4. Details of claim (including details of the injury / illness):

- I /We certify that this claim form has been completed in full and all required information and documentation as specified on this claim form is attached to this signed form.
- I/We certify that the information given in this form is true, accurate and complete to the best of my/our knowledge, information and belief. No information that is likely to affect this claim has been withheld.
- I/We understand that this claim may be refused if any information provided in this claim is untrue or inaccurate or if any information relevant and material to this claim has been withheld.
- I/We consent to the collection and use of the claimant's personal information by you for the purposes of your assessment of this claim and to the disclosure of such information to any person as you deem appropriate.
- I/We acknowledge that if I/we do not agree to the collection of this personal information then you will be unable to assess this claim and no benefit will be payable.
- I/We agree that I/we will provide all necessary assistance as you may require in processing this claim.

NAME:

SIGNATURE:

DATE:

/ /

Please send the completed claim form and supporting documents to us at:

HSBC Insurance (Singapore) Pte. Limited
Corporate Claims Department
10 Eunos Road 8 #11-01
Singapore Post Centre
(South Lobby)
Singapore 408600

Tel: (65) 6225 6111
Fax: (65) 6732 9857