

Accident Claim Form

In order for us to process your claim, please submit the following:

1. Accident Claim Form (duly completed and signed by policyowner)
2. 2 Clinical Abstract Application Forms
3. Copy of Medical Certificate
4. Medical Reports from attending doctor(s)
5. Copy of Newspaper report (if any)
6. Copy of Police Report (if any)

For any queries, please contact your Financial Planner or our Customer Service Officers at (65) 6225 6111.

Note:

- i. The claim will only be processed upon receipt of all relevant documents. Should additional documents be required, we will contact you.
- ii. The Accident Claim form must be completed and returned to us within twenty (20) days from date of accident.
- iii. Additional medical report fee incurred during the process of the claim is at the expense of the claimant.
- iv. The Company does not admit liability by the mere issue of the claim form.

“The Company” refers to HSBC Insurance (Singapore) Pte. Limited.

For Takaful policy, please read “certificate” for policy, “certificate holder” for policyowner, “wakil” for financial planner, “participant” for life insured, “takaful benefit” for sum insured.



HSBC Insurance (Singapore) Pte. Limited. (Reg. No. 195400150N)
 21 Collyer Quay #02-01 Singapore 049320, Monday to Friday 9.30 am to 5 pm. www.insurance.hsbc.com.sg
 Customer Care Hotline: (65) 6225 6111 Fax: (65) 6221 2188
 Mailing address: Robinson Road Post Office P.O. BOX 1538 Singapore 903038

Accident Claim Form

(A) Personal particulars			
Policy no.:		Name of policyowner:	
NRIC no.:	Date of Birth:	Sex:	Telephone:
Residential Address:			
(B) Details of occupation(s)			
1. Present occupation (if more than one, state all):			
2. Name of present employer:		Telephone:	
		Address:	
3. List exact duties performed at work:			
4. Did you submit a medical leave certificate to your employer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(C) Nature of claim & related details			
5. Date and time of accident			
6. Nature of accident (State in detail, how and where it happened)			
7. Describe in detail the injuries sustained, indicating the part of the body injured and the type of injury (eg. fracture, cut, bruise, etc.)			
8. Name and address of doctor(s) who treated you for the injury: Date consulted			
a.			
b.			
c.			
9. Details of hospitalisation: (Please attach Discharge Note)			
a. Name of hospital			
b. Period of hospitalisation		From _____ to _____	
10. Date on which you last worked prior to disability			
11. Date on which you returned to work			
12. Date on which you expect to return to work if you have not already done so			
13. If after your return to work you were not immediately able to perform all your duties, indicate :			
a. Date of your return to work			
b. Details of duties you were not immediately able to perform			
c. Date on which you were finally able to perform all your duties			
14. Are you presently insured for accident benefits with other companies? If so, state :			
<u>Name of insurance company effected</u>	<u>Policy no./ Certificate no.</u>	<u>Amount of benefits</u>	<u>Date insurance</u>
(D) Declaration & 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 photocopy of this authorisation shall be considered as effective and valid as the original.			
Signature of witness		Signature of insured	
Name :		Date :	
NRIC no.:			
Date :			
Note : No fees, commissions or charges of whatever nature are payable to agents or employees of the company in respect of this claim.			

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Clinical Abstract Application Form

Instructions

1. This form must be fully completed for the application of a medical report. It should be signed by the patient or the patient's parent (if patient is below 21 years of age) or the patient's next-of-kin (if patient is deceased), and be duly witnessed.
2. This form is to be submitted with the appropriate report fee.
3. The release of the medical report is subject to official approval.

Medical Superintendent

_____ Hospital

Singapore _____

I, _____ NRIC No. _____
(Name)

of _____
(Address)

hereby authorise you to furnish **HSBC Insurance (Singapore) Pte. Limited** of 21 Collyer Quay, #02-01, Singapore 049320, with a medical report on

_____ NRIC/Hospital Registration No. * _____
(Name of patient)

who was treated at the hospital as a patient in the department of _____ from _____
to _____.

The medical report is required for the purposes(s) specified below:

Besides the medical report fee I undertake to pay any additional charges such as X-ray and Laboratory Investigation Charges which may be incurred in the preparation of the medical report.

Signature of patient / parent / next-of-kin

Name (in block letters)

Relation to patient

Duly Witnessed By:

Signature of witness

Name (in block letters)

NRIC No.

Address

For official use

Application is approved / not approved

Signature and date

Name and designation of approving officer

* Delete as appropriate

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