HSBC Insurance

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

Critical Illness Claim Form

In order for us to process your claim, we require the following:

1. Critical Illness Claim Form (duly completed and signed by policyowner)
2. 2 Clinical Abstract Application Forms
3. Medical Reports from attending doctor(s)
4. Relevant laboratory reports (ie. histopathology report, biopsy report, CT-scan results, ECG results, etc.)
5. Copy of NRIC / Identification document of Policyowner

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

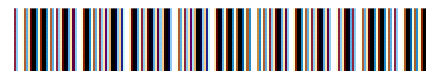
The personal data which you have submitted is being collected for the purposes stated in the HSBC Data Protection Policy. For more information on how we manage your personal data, please visit http://www.hsbc.com.sg/1/2/miscellaneous/privacy-and-security.

Note:

i. The claim will only be processed upon receipt of all relevant documents. Should additional documents be required, we will contact you.
ii. Additional medical report fee incurred during the process of the claim is at the expense of the claimant.
iii. The Company does not admit liability by the mere issue of the claim form.
iv. We aim to settle most claims within 8 working days on receipt of all required documents. Please note that more time may be needed for claims which require further clarification. We will keep you closely updated on the status.

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

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



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Critical Illness Claim Form

(A) Personal particulars

Policy number:		Name of Policyowner:	
Name of Life Insured:		Relation to 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:

(C) Nature of claims & related details

(1) Describe fully the extent and nature of your illness.

(2) On what date did you first consult a medical practitioner in connect with your illness?

(3) Have you previously suffered from, or received treatment for a similar or related illness? If "yes" give full details.

(D) Record of medical consultations

(1) Give below the details of any doctors or specialists who have been consulted in connection with your illness

	Name	Address	Date
a.			
b.			

(2) Please provide the name and address of your usual medical attendant if different from above.

(E) 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) Are you insured for similar benefits with any other insurers? 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.

	Name of insurer	Amount of benefits
a.		
b.		

(F) Payment Option (not applicable for policies bought under CPF Investment Scheme and Supplementary Retirement Scheme Accounts)

Please indicate the option you wish to receive your payment. If no option is selected, a cheque will be sent to you.

- ☐ Cheque
- ☐ Self- collect at Customer Service Centre (21 Collyer Quay #02-01 Singapore 049320)
- ☐ Direct credit into my HSBC savings or current account HSBC bank account number:_______________________________

When direct credit option is selected, you will need to submit a **valid copy of your bank book/statement** for account verification. We will send a cheque to you if:
1) you have indicated a third-party bank account
2) the direct credit option is selected without submission of a valid copy of bank book/statement
3) you have provided a non-Singapore bank account number

(G Declaration & authorisation

I hereby declare that the statements and answers given above are true and complete to the best of my knowledge and belief 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 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/participant/claimant
Name :	Date :
NRIC no.:	
Date	

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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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