

**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](http://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

## **Total and Permanent Disability Claim Form**

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

1. Total and Permanent Disability Claim Form (duly completed and signed by policyowner)
2. 2 Clinical Abstract Application Forms
3. Medical Reports from attending doctors (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. 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.

“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.



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**Total and Permanent Disability Claim Form**

<b>(A) Personal particulars</b>			
Policy no.:		Name of policyowner:	
Name of life insured:		Relation to policyowner:	
NRIC no.:	Date of birth:	Sex:	Telephone:
Residential address:			
<b>(B) Details of occupation(s)</b>			
	<i>Before Disability</i>	<i>After Disability</i>	
(1) Occupation			
(2) Name of employer			
(3) Address of employer			
(4) Average monthly income			
(5) List exact duties performed at work			
<b>(C) Details of disability</b>			
(1) Is the disability suffered due to:	<input type="checkbox"/> illness (date symptoms started _____ ) <input type="checkbox"/> accident (date/time of accident _____ )		
(2) Describe in detail all symptoms and/or nature of injuries/ disability suffered			
(3) Date on which you last worked prior to your disability			
(4) Are you wholly confined to your bed or house?			
(5) Date on which you returned to work			
(6) Date on which you expect to return to work if you have not already done so			
<b>(D) Details of physician(s) or hospital(s) admitted for this disability</b>			
<u>Name(s)</u>		<u>Date of admission</u>	
<b>(E) Details of your regular physician or any other physician(s) consulted for any other disorders in the past three years.</b>			
<u>Name(s)</u>		<u>Reason for consultation</u>	
<b>(F) Other claims</b>			
Are you presently insured for disability benefits with other companies? If so, please state:			
<u>Name of company</u>		<u>Amount of benefits</u>	
<b>(G) Declaration &amp; authorisation</b>			
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 Name : NRIC no.: Date :		Signature of policyowner 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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