

PART 1
**Authorisation For Release Of Medical Information Form
 (To be completed by Insured Member)**

A. ADMINISTRATIVE	
Policy Number:	Policy Owner's Name:
Patient's Date of Birth:	Gender: M / F
Patient's NRIC / FIN / ID / Passport No:	Patient's Full Name:
Email Address:	Date of Employment: (For Group Policy)
	Patient's Contact Number:
B. DECLARATION AND AUTHORISATION	
<p>I confirm I am the patient / patient's parent / patient's spouse / patient's legal guardian* (circle where applicable) and wish to claim under the above policy and I declare that the statements stated are true and complete to the best of my knowledge and belief.</p> <p>I hereby authorise HSBC Life (Singapore) Pte. Ltd. or its representative(s) to request from any physician, hospital, dentist, person or organisation (including the Policy Owner (the "Employer"), all information with respect to any illness, injury, medical history, consultations, billing information, prescriptions or treatment and copies of all hospital and medical records concerning me and/or the patient at any time and authorise the prior mentioned organisations to disclose all such information to HSBC Life (Singapore) Pte. Ltd. or its representative(s). A photocopy of this authorisation shall be considered as effective and valid as the original.</p> <p>In connection with my/our application or declaration, I/We give consent for HSBC Life (Singapore) Pte. Ltd. ("HSBC Life") and its representatives or agents to collect, use, store, transfer and/ or disclose the information (including that provided by sources other than myself) concerning me/us and/or my dependents, to or with all such persons (including any member of the HSBC Group or any third party service provider, and whether within or outside of Singapore and my Employer when claiming under a Group Policy) for the purpose of enabling HSBC Life to provide me/us and/or my/our dependents (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/or managing my/our claims or my Employer's Group Policy(ies) with HSBC Life (as the case may be), and for the purposes set out in the Data Use Statement which can be found at www.hsbclife.com.sg ("Purposes").</p> <p>Full Name: _____</p> <p>NRIC / FIN / ID / Passport No: _____</p> <p>_____</p> <p>Contact Number: _____</p> <p>_____</p> <p><i>(Applicable if details are different from Section A and patient is a minor)</i></p> <p>Patient's Signature: _____</p> <p>Patient's Full Name: _____ Date: _____</p>	

PART 2
Pre - Admission Form
(To be completed by Treating Doctor Only)

Patient's Full Name:	NRIC / FIN / ID / Passport No:
Date of Admission: DD / MM / YYYY	Admitting Hospital:
1. MEDICAL SECTION:	
a. Symptoms Presented:	b. Admitting Diagnosis and ICD 10:
c. Date the patient first consulted you for this illness/injury? (DD / MM / YYYY)	d. Date the patient first became aware of any signs or symptoms for this illness/injury? DD / MM / YYYY
e. If this condition existed before symptoms became apparent to the patient, please indicate when, in your professional view this condition began to develop? DD / MM / YYYY	f. What is the cause of the illness/injury?
g. Any previous consultation, treatment, hospitalisation for this illness/injury? If YES, please provide details as below: <u>Date</u> <u>Details of treatment</u> <u>Name of doctor</u> <u>Hospital / Clinic contact details</u>	
2. Is the admitting diagnosis in relation to:	
	If Yes, Please give details
a. Pregnancy, Childbirth, Complication of Pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Is Pregnancy a result from a natural conception?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Infertility, impotence, erectile dysfunction or any contraceptive treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Sleep disorders, Sleep Apnea, Obesity or Weight management?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Self-inflicted injuries, injuries resulting from attempted suicide, alcohol /drugs/ substance abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Sexually Transmitted Disease (STD), AIDS/any conditions resulting from or related to HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Congenital anomalies, Psychiatric, Mental illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Work Related Accident / Injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Dental conditions, Cosmetic or Aesthetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. TREATMENT DETAILS & COST ESTIMATES:	
Treatment details or Surgical Procedure(s):	
Surgical Operation Code(s) TOSP:	
Hospital charges:	Surgery Fees:
Length of Stay (DAY):	Daily Attendance Fees:
Anaesthetist Fees:	Doctor Other Fee (please give details if any):
4. Please provide copies of Referral letter, Financial counseling, Diagnostic test results / reports	
<hr/> Signature of Treating Doctor & Official Stamp of Clinic/Doctor	Name of Treating Doctor: Date: