

Medical History Form

This form is to be completed for Insured Member who is currently seeking specialist treatments. Completion of this form does not indicate acceptance of continued cover with the specialist.

Please note pursuant to Section 25(5) of the Insurance Act (Cap. 142), you are to disclose in this form fully and faithfully all the facts which you know or ought to know, otherwise nothing may be payable under the policy.		
Policyholder (Employer)	Policy Number	
Insured Member (Employee)	NRIC / Passport	Date of Birth
Occupation	Date of Employment	Sex F <input type="checkbox"/> M <input type="checkbox"/>

If patient is the dependant, please complete details below

Name of Dependant		NRIC No / Passport	Date of Birth
Occupation	Relationship Spouse <input type="checkbox"/> Child <input type="checkbox"/>	Date of Birth	Sex F <input type="checkbox"/> M <input type="checkbox"/>

Nature of Illness / medical condition being treated	Onset of illness and frequency of follow-up	Name and address of attending specialist(s)	Date of 1) First Treatment 2) Last Treatment 3) Next Treatment
			1) 2) 3)
			1) 2) 3)
			1) 2) 3)
			1) 2) 3)

(This part must be signed by the patient or patient's parent / legal guardian if the patient is below 21 years of age)

I / We hereby authorise **HSBC Life (Singapore) Pte. Ltd.** ("HSBC Life") to request from any physician, hospital, dentist, person or organisation (including the Policyholder (the "Employer"), all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment and copies of all hospital and medical records concerning me / us and/or my dependants (where applicable) at any time and authorise the prior mentioned organisations to disclose all such information to **HSBC Life**. A photocopy of this authorisation shall be considered as effective and valid as the original.

I / We declare that the statements and answers stated are true and complete to the best of my / our knowledge and belief.

In connection with my / our claim, I / we give consent for **HSBC Life (Singapore) Pte. Ltd.** (collectively "HSBC Life") and their respective 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 dependants, 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 the Employer when claiming under a Group Policy) for the purpose of enabling **HSBC Life** to provide me / us and/or my dependants (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/ or managing my / our claims or the 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")."

Signature of Employee

Signature of Patient (if patient is dependants)

Date (DD/MM/YY)