HSBC Life

Group Total & Permanent Disability Claim Form

Instructions:

Please notify and provide proof of claim within 90 days from the date Total & Permanent Disability (TPD) is certified and confirmed by a Medical Practitioner:

(1) Duly completed Part 1 of TPD Claim Form (to be completed and signed by an authorised signatory stated in MAS 314).

(2) Medical Report* (to be completed by the attending Physician. Cost of the Medical Report is to be borne by the Claimant).

(3) Copy of MRI / CT Scan / Histology / X-ray / Laboratory Reports.

(4) Certified true copy of Birth Certificate / Passport / Identity Card of Insured Member (must be certified by an authorised signatory stated in MAS 314).

(5) Certified true copy of Latest pay slip two month before month of diagnosis (must be certified by an authorised signatory stated in MAS 314).

(6) A copy of the police report if Total & Permanent Disability occurs due to an accident

Notes:

(1) We reserve the right to pursue for any documents that are not mentioned above if they are deemed necessary.

(2) Claims settlement will be made payable to the Policyholder.

(3) * Please furnish us with an updated Medical Report after six months from the date of disability.

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Total & Permanent Disability Claim Form

PART 1 (TO BE COMPLETED BY CLAIMANT)

A. CLAIMANT'S PARTICULARS

Policyholder (Employer)				Policy No.		Membership No.
Insured Member (Employee)	Date of Birth	Sex ☐Female ☐Male	NRIC/Passport No./BC No	Occupation	Date of Employment	Sum Insured
Insured Dependant (if applicable)	Date of Birth	Relationship ☐Spouse ☐Child	NRIC/Passport No./BC No	Occupation	Effective date of Insurance	Sum Insured

B. DETAILS OF OCCUPATION AND BENEFITS

	Before disability	After disability
1) Occupation		
2) Name of employer		
3) Average monthly income		
4) Date salary was last adjusted		
5) List exact duties performed at work		

C. DETAILS OF DISABILITY

1) Is the disability suffered due to :	☐ Illness - Date symptoms first started: ☐Accident - Date/Time/Description of accident:
2) Describe in details all symptoms and /or nature of injuries / disabilities suffered.	
3) Date last actively at work	Date :
4) Are you currently confined to your bed or house?	☐Yes ☐No
5) If Yes, please provide details	
6) If No, please provide date you return to work	Date :

DETAILS OF DOCTOR(S) OR HOSPITAL(S) IN CONNECTION FOR THIS DISABILITY

Name of Hospital / Clinic / Doctor and address	Dates treated

Details of your regular doctor or any other doctor(s) consulted for any other disorders in the past 3 years

Name of Hospital / Clinic / Doctor and address	Reasons for consultation

Declaration and authorisation

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

I hereby authorise HSBC Life (Singapore) Pte. Ltd. ("HSBC Life") to request from any physician, hospital, dentist, person or organisation (including my 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 and/or my dependants 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. ("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").

Signature of Employee	Signature of Patient (for dependant above age 21)	Date (DD/MM/YY)

E. TO BE COMPLETED BY EMPLOYER

Signature of Employer	Company's Name and Stamp	Date (DD/MM/YY)

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PART 2 – MEDICAL REPORT (TO BE COMPLETED BY ATTENDING PHYSICIAN) (Medical Report fee to be borne by patient)

Patient Name	NRIC / Passport No / BC No
Policyholder (The Employer)	Policy Number
1. Are you the patient's regular medical doctor? If 'yes' over what period do your records extend?	
2. Diagnosis (Describe the nature and severity of the disability)	
3. When you first consulted for this disease and, how long had symptoms been present?	
4. Date of diagnosis of disability :	
5 Was the diagnosis made know to the patient? a. [ ] If 'yes', when was the date patient first made aware?	
b. [ ] If 'no', reason for not disclosing the diagnosis to patient.	
6. Date of last consultation / examination	
7. Date when first absent from work	
8. To what extent does his disability prevent him from performing all normal duties of his usual occupation	
9. If he is unable to return to his usual occupation, can he engage in any other type of occupation?	
10. Describe treatment, including any operations performed.	

11. Has patient been treated previously for the same illness / injury (ies) or any related condition? If 'yes', please state:

Name Of hospital/Clinic/Doctor and address	Date treated

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12. Provide the name of any hospitals / clinics to which the patient had been referred together with the names of the doctor(s) who had attended to the patient.		
Name Of hospital / Clinic and address	Name of doctor(s)	Date referred
13. Is the patient suffering from any other conditions? If yes, does this have effect on the condition above?		
14. If there is any further information which, in your opinion, will assist us in assessing this claim, please furnish such information here.		

15. In your opinion, does the patient fulfil the Total & Permanent Disability's definition stated below?

☐ Yes ☐ No

Definition of Total & Permanent Disability:

This is defined as a disability caused by an accident or an illness, which is TOTAL, CONTINUOUS AND PERMANENT. It must result in a COMPLETE INABILITY to work in any occupation to earn an income for at least 6 continuous months after the start of the disability.

I ……………………………………………………………………………………………..the undersigned, do hereby declare that I was the physician in attendance during the last illness of ………………………………………………………………………… and that the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from the Company.

Date :____________________

Signature : ____________________

Professional Qualification : ____________________

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Postal Address : ____________________

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Clinic or Hospital Stamp