HSBC Life (Singapore) Pte. Ltd. (Reg. No. 199903512M)
www.hsbclife.com.sg
Customer Care Hotline: (65) 6880 4888 Email: e-surance@hsbc.com.sg
Mailing Address: Robinson Road Post Office P.O. BOX 1538 Singapore 903038

Hospitalisation Claim Form

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

1. Hospitalisation Claim Form (duly completed and signed by Claimant)
2. 2 Clinical Abstract Application Forms
3. Copy of Board & Room Invoice from attending Hospital
4. Copy of Medical Report/Inpatient Discharge Summary/Doctor's memo (if any)
5. Copy of NRIC / Identification document of Claimant

For any queries, please contact your Financial Consultant or our Customer Service Officers at (65) 6880 4888.

Note:

i. The claim will only be processed upon receipt of all relevant documents. Should additional documents be required, we will contact you.
ii. The Hospitalisation Claim Form must be completed and returned to us within 30 days after leaving the hospital.
iii. Additional medical report fee incurred during the process of the claim is at the expense of the claimant.
iv. The Company does not admit liability by the mere issue of the claim form.
v. 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 Life (Singapore) Pte. Ltd.

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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Hospitalisation Claim Form

(A) Personal particulars			
Policy number:		Name of Claimant:	
NRIC no.:	Date of birth:	Sex:	Telephone no.:
Residential Address:			
Name of Life Insured (if different from Claimant):		Relation to Claimant:	

(B) Please give details of the hospitalisation	
Name of hospital	
Admission no.	
Name and no. of ward	
Name of doctors who treated the Life Insured in hospital	
Hospital's diagnosis	
What surgery(s) was/were done?	
Please tick if Life Insured had done:	❑ X-ray ❑ ECG ❑ Blood Tests ❑ Other investigations, please specify:
Was the Life Insured pregnant at the time of hospitalisation? If "yes", for how many months?	

(C) Please complete if hospitalisation was due to accident:	
When did it happen?	Date:_____ Time:_____
Briefly describe how did it happened.	
Briefly describe the injuries.	

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(D) Please complete if hospitalisation was due to illness:

Please give a brief description of Life Insured's symptoms.

How long had Life Insured been having these symptoms prior to admission to hospital?

Please provide details of the Doctors consulted:

	Date consulted	Name & Clinic name/Address
Doctor first consulted for this illness		
Doctor who referred the Life Insured to hospital		
All other doctors consulted during this illness		
Doctors seen for any similar condition in the past		

(E) 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:

❑ ^ PayNow NRIC No.: _____ ^ Your Singapore NRIC number must be linked to a PayNow account.

❑ Cheque ❑ Self-collect at Customer Service Centre (38 South Beach Road, #03-11, South Beach Tower, Singapore 189767)

❑ * Direct credit into my bank Name of Bank :_____
Account Number :_____

* For payment via Direct Credit, bank charges, currency exchange and all other incidental costs related to the transfer will be borne by you. If the Direct Credit option is selected, please submit a scan/image of your bank statement, clearly showing your full name, bank account number and bank's logo/ emblem for account ownership verification.

We will send a cheque to you if:

1) "PayNow" option is selected but you have indicated a mobile number/ FIN number, or your Singapore NRIC number is not linked to a PayNow account.
2) "Direct Credit" option is selected and
   - you have indicated a bank account belonging to a third-party or
   - you have NOT submitted a clear image/copy of bank statement with all required information in a language we support
3) No payment option is selected

(F) Declaration & authorisation

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/the Life Insured or examined me/the Life Insured for any reason, to disclose to HSBC Life (Singapore) Pte. Ltd. any and all information with respect to any illness or injury and to provide HSBC Life (Singapore) Pte. Ltd. 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.

I understand and acknowledge that the personal data which I am submitting is being collected for the purposes stated in the Company's Data Privacy Policy (which may be found at https://www.insurance.hsbc.com.sg/privacy-and-security/) and consent to the collection, use and disclosure of my personal data accordingly.

_____
Signature of Policyowner / Trustee / Assignee
Name :
Date :

_____
Signature of Witness
Name :
ID 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. Please scan and upload completed form.

Note: Any medical report fee (if applicable) will be borne by the claimant. 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 Life (Singapore) Pte. Ltd.** of New Business/Claims team, 10 Marina Boulevard, Marina Bay Financial Centre Tower 2, #48-01, Singapore 018983, 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 purpose(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.

I understand and acknowledge that the personal data which I am submitting is being collected for the purposes stated in the Company's Data Privacy Policy (which may be found at https://www.insurance.hsbc.com.sg/privacy-and-security/) and consent to the collection, use and disclosure of my personal data accordingly.

_____	_____
Signature of patient / parent / next-of-kin	Signature of witness
Name (in block letters) : _____	Name (in block letters) : _____
Relation to patient : _____	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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_____
Signature of patient / parent / next-of-kin

Name (in block letters) : _____
Relation to patient : _____

_____
Signature of witness

Name (in block letters) : _____
NRIC No. : _____
Address : _____

For official use

Application is approved / not approved

_____
Signature and date

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Name and designation of approving officer

* Delete as appropriate