HSBC Insurance (Singapore) Pte. Limited (Reg. No. 195400150N)
21 Collyer Quay #02-01 Singapore 049320 Monday to Friday 9:30am to 5pm www.insurance.hsbc.com.sg
Customer Care Hotline: (65) 6225 6111
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 Claimant)
2. 2 Clinical Abstract Application Forms
3. Medical Reports from attending doctors (if any)
4. Copy of NRIC / Identification document of Claimant

For any queries, please contact your Financial Consultant or our Customer Service Officers at (65) 6225 6111.

The personal data which you have submitted is being collected for the purposes stated in the HSBC Data Protection Policy. For more information on how we manage your personal data, please visit http://www.hsbc.com.sg/1/2/miscellaneous/privacy-and-security.

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.
iv. 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 Insurance (Singapore) Pte. Limited.

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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Total and Permanent Disability 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) Details of occupation(s) of the Life Insured		
	Before Disability	**After Disability**
Occupation		
Name of employer		
Address of employer		
Average monthly income		
List exact duties performed at work		

(C) Details of disability of the Life Insured

Is the disability suffered due to
- ❑ Illness (Date symptoms started: _____)
- ❑ Accident (Date/time of accident: _____)

Describe in detail all symptoms and/or nature of injuries/ disability suffered.

Date on which the Life Insured last worked prior to the disability.	
Is the Life Insured wholly confined to the bed or house?	❑ Yes ❑ No
Date on which the Life Insured returned to work.	
Date on which the Life Insured expect to return to work if he/she has not already done so.	

(D) Details of physician(s) or hospital(s) admitted for this disability

Name(s)	Date of admission

(E) Details of regular physician or any other physician(s) consulted for any other disorders in the past three years.

Name(s)	Reason for consultation

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(F) Other claims

Is the Life Insured presently insured for disability benefits with other insurers? If so, please state:

Name of company	Amount of benefits

(G) 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 (21 Collyer Quay #02-01 Singapore 049320)

❑ * Direct credit into my savings or current account Bank and 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 copy of your bank book / statement for account 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 copy of bank book / statement or
   - you have provided a non-Singapore bank account number
3) No payment option is selected.

(H) 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 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 / Trustee / Assignee
Name :
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 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.

_____
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

_____
Name and designation of approving officer

* Delete as appropriate

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