* C L A I M F *

MEDICAL CLAIM FORM

IMPORTANT: Please furnish the following documents to Singapore Life Ltd. for your Medical claim:

1. All sections of our forms must be duly completed to avoid unnecessary delay. Indicate as "N.A." if not applicable.
2. Where softcopies are submitted to us, please retain the original document for at least 6 months as we may request to sight the original copy.
3. For claim on Hospitalisation / Day Surgery / Other Medical Benefit, Section E of the Claim Form needs to be completed by the attending doctor/surgeon.
4. Any fees for completion of Doctor's Statement and/or medical evidence shall be borne by the Claimant(s).
5. All overseas documents must be certified by a Notary Public of the Country where documents are produced.
6. All documents must be in English. Any documents which are in foreign languages must be officially translated to English by a certified translator/interpreter.
7. Please provide the following documents (where applicable):
   a) Copy of the Inpatient Discharge Summary
   b) Copy of any diagnostic reports, radiology, X-ray reports, laboratory evidence and any relevant hospital reports
   c) Copy of final hospital / medical invoices and receipts (Interim invoices are not acceptable)
   d) Copy of claim settlement letter if there was reimbursement of medical expenses from another insurance policies (if any)
   e) Copy of MediSave Transaction Statement or Healthcare Payments and Claims Statement from CPF Board if there was payment using MediSave or MediShield Life (if any)
8. The Life Assured/Assured will be responsible for the accuracy and integrity of the information provided. Failure to provide details or disclose all relevant information may delay the claim assessment.
9. The acceptance of this form is not an admission of liability on the part of Singapore Life Ltd. Any documentary proof or report required by us shall be furnished at the expense of the claimant.

POLICY NUMBER(S):		
Type of Claim Please tick (✔) the appropriate box:	❒ Annuity Medical	❒ Biennial Medical
	❒ Health Screening	❒ Hospitalisation / Day Surgery / Other Medical Benefit

Section A: Details of Assured/Policyholder & Life Assured

Name of Life Assured	NRIC/FIN/Passport/Birth Certificate No.	
Occupation	Date of Birth (dd/mm/yyyy)	Gender
Name of Assured/Policyholder **(If different from Life Assured)**	NRIC/FIN/Passport No.	

Details of Illness / Injury

1) Date symptoms 1st started (dd/mm/yyyy)
2) Describe the symptoms 1st presented
3) Date 1st consulted doctor for the condition (dd/mm/yyyy)

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4) Details on the Bills/Receipts **(Applicable for Annuity Medical / Biennial Medical / Health Screening Benefits Only)**			
Date for Bills/Receipts incurred (dd/mm/yyyy)	Type/Description of Consultation/Check-up	Name of Doctor(s)	Name & Address of Clinic(s)

5) Name & Address of the doctor 1st consulted for the condition

6) Final Diagnosis

7) Date of Diagnosis (dd/mm/yyyy)

8) Date of Admission (dd/mm/yyyy)

9) Date of Discharge (dd/mm/yyyy)

10) Date of Operation, if any (dd/mm/yyyy)

11) What was the treatment (including any surgery) given to the Life Assured?

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12) Name and address of doctor/specialist who attended to the Life Assured during the hospital's confinement

13) Name and address of all doctor(s) consulted for the condition

14) Name and address of all Family/Regular/Company Doctor(s) consulted for minor ailments (eg flu, fever, cough), Diabetes Mellitus, Hypertension (High Blood Pressure), Hyperlipidemia (High Cholesterol) and any other conditions

15) Is the Life Assured claiming Medical Expenses, Workman's Compensation from any other source? ❒ Yes ❒ No
If "Yes", please provide the details below and the claim settlement letter from the other party.

Name of Insurance Company, Employer, Third Party, etc	Policy Number	Nature of Claim	Amount Claimed

If the Illness/Injury resulted from an Accident, please complete this section.

1) Place of Accident

2) Date and Time of Accident

3) Describe in detail how the accident happened

4) Nature and extent of injuries

Section B: Mode of Payment

For a better payment experience, SGD payments to the Assured (Policyholder) will be credited to the bank account linked to the Assured (Policyholder)'s PayNow-NRIC/FIN. Please check that you have registered for PayNow with your bank, using your NRIC/FIN.

Section C: Declaration on Beneficial Owner

Note: This is only applicable if the recipient of the proceeds is a legal person or a legal arrangement.

❒ I/We declare that there is no change in Beneficial Owner(s).

Otherwise, please submit the Declaration of Beneficial Owner Form together with this form if there is any change in the Beneficial Ownership. You may find the Declaration of Beneficial Owner Form in our website www.singlife.com.

"Beneficial owner" means the natural person who ultimately owns or controls the customer or the natural person on whose behalf business relations are established and includes any person who exercises ultimate effective control over a legal person or legal arrangement.

"Legal person" means an entity other than a natural person that can establish a permanent customer relationship with a financial institution or otherwise own property.

"Legal arrangement" means a trust or other similar arrangement.

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Section D: Declaration and Authorisation

Name of Life Assured		NRIC / FIN / Passport / Birth Certificate No.	

I/We hereby declare that the answers given by me/us in this Form are in every respect true and correct and that no material information or circumstance has been withheld or omitted.

I/We declare that I/We am/are not an undischarged bankrupt. There are currently no actual or pending bankruptcy proceedings against me/us and I/We have not assigned the Policy to any other party.

I/We agree that:

a) this claim signifies my/our consent to Singapore Life Ltd. to obtain medical information from any doctor whom the Life Assured has consulted and I/We authorise the doctor to release such information to Singapore Life Ltd.
b) Singapore Life Ltd. may release any relevant information concerning the Life Assured (including medical information) to any third party, which Singapore Life Ltd. deems necessary.
c) any third party who has received any information concerning the Life Assured may also obtain medical information from any doctor whom I/We have consulted, and I/We authorise the doctor to release such information to the third party. The third party may also release relevant information concerning the Life Assured (including medical information) to any other party for any purposes related to the Life Assured's application or my/our claim for the benefits.
d) a photocopied copy of this form shall be treated as valid and binding as if it is the original.

I/We declare and undertake that I/We have submitted the actual bills and receipts (including electronic/digital copies) issued by the medical institutions.

I/We understand that Singapore Life Ltd. has the right to:

a) ask for originals/certified true copies of the bills and receipts, or contact the medical institution directly, to confirm that the bills and receipts are original.
b) reject claims, recover amounts paid or impose additional charges, if the claim is false or where there are multiple claims made.

I/We consent to Singapore Life Ltd. ("Singlife") (and Singlife related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s) and/or managing my/our relationship with Singlife.

I/We also consent to Singlife (and Singlife related group of companies) disclosing and transferring my/our personal data to Singlife (and Singlife related group of companies) and their respective third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

I/We have read and understood Singlife's Data Protection Notice which may be found at www.singlife.com/pdpa. Singlife's Data Protection Notice may be updated from time to time without notice. I am aware that I should visit your website regularly to ensure that I am well informed of the updates.

Note: If you are filling up this form on behalf of another person or whereby you are disclosing personal data to us other than yours, you are required to inform such person(s) of the purpose and obtain his/her consent before submitting this form to us. Once you have submitted, you will be deemed to have obtained the necessary consent for us. Further, you understand that you will be responsible to Singlife for any loss or claim arising out of your failure to obtain consent of the person who you have disclosed.

Signature / Thumbprint / Company's Stamp (if applicable)	Date (dd/mm/yyyy)
Name of Assured/Policyholder	
NRIC / FIN / Passport No.	
Email	
Mobile No.	Home/Office Tel No.
Residential Address * Country	Postal Code
Signature of Life Assured who is 21 years old or above (if different from Assured/Policyholder)	Date (dd/mm/yyyy)

[#] **Note:** All correspondence will be sent to the mailing address as per our existing record.

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SECTION E: DOCTOR REPORT (TO BE COMPLETED BY THE ATTENDING DOCTOR / SURGEON)

(Note: The medical report fee, if any, will be borne by the claimant.)

Patient's Name:	**NRIC/FIN/Passport No:**	**Date of Treatment:** (dd/mm/yyyy)
1) Final Diagnosis:	2) ICD10 Code:	3) Date of Diagnosis: (dd/mm/yyyy)
4) Underlying Cause(s) of the Illness / Injury:	5) Other Diagnosis (including ICD10 Code):	

6) Is the condition / treatment / surgery related to any of these?
☐ Yes ☐ No If "Yes", please provide more details:

- ☐ Pregnancy or Childbirth
- ☐ Abortion or Miscarriage
- ☐ Infertility or Sub-fertility Condition
- ☐ Sexually Transmitted Disease
- ☐ Congenital Anomaly
- ☐ Genetic or Chromosomal Disorder
- ☐ Mental or Psychiatric Condition
- ☐ Cosmetic Reason

7) When did the patient first consult you for this condition? (dd/mm/yyyy)	8) How long has the condition existed prior to consulting you?
9) Approximate date of discovery of the condition: (dd/mm/yyyy)	10) Given the etiology of the condition, please state the estimated date of such condition would be in existence: (dd/mm/yyyy)
11) What were the symptoms / complaints prior to consulting you?	12) Please give the date the symptoms first started.

13) If there is no symptom presented, what prompted the patient to see you?

14) Has the patient ever had the same or similar condition / symptom? If "Yes", please indicate the date of occurrence and describe: (dd/mm/yyyy)
☐ Yes ☐ No ☐ Not to my knowledge

15) Was the patient referred to you by another doctor? ☐ Yes ☐ No If "Yes", please provide a copy of the **referral letter** and the following information:

Name of Doctor	First Consultation Date	Name of Clinic	Address

16) Did the patient ever consult any other doctor(s) previously for the above condition? ☐ Yes ☐ No ☐ Not to my knowledge
If "Yes", please provide the following information:

Name of Doctor	First Consultation Date	Name of Clinic	Address

17) Please provide us with the patient's regular doctor's name, clinic and address.

Name of Doctor	Reason for consultation(s)	Name of Clinic	Address

18) Is the patient still under your care for this condition? ☐ Yes ☐ No If "Yes", please state the estimated duration that patient needs to follow up with you. If "No", please give date of last visit.	19) Please provide the following if patient was referred to another doctor. a) Doctor's Name & Clinic: b) Reason for Referral: c) Date of Referral: (dd/mm/yyyy)

20) Does the patient suffer from any other medical condition(s)? ☐ Yes ☐ No
If "Yes", please state the medical condition(s) and the date of diagnosis:

21) Please state the surgical procedure(s) performed. If there's no surgical procedure, please state the treatment /medication given.	22) If surgical procedure(s) was performed, please provide the following: Surgical Procedure Code / Date (dd/mm/yyyy) / Name of Surgeon

23) If excision was performed, please state the size of the lesion / tumor and provide a copy of the Histology Report.

I hereby declare that the above answers are true to the best of my knowledge and belief.

Name and Designation	Signature of Physician / Surgeon
Name and Address of Clinic / Hospital & Stamp	Date (DD/MM/YYYY)