



MEDICAL CLAIM FORM

IMPORTANT: Please read before completing this claim form.

- All sections of our forms must be duly completed to avoid unnecessary delay. Indicate as "N.A." if not applicable.
- 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.
- For claim on Hospitalisation/Day Surgery/Other Medical Benefit, Section E of the Claim Form needs to be completed by the attending doctor/surgeon.
- Any fees for completion of Doctor's Statement and/or medical evidence shall be borne by the Claimant(s).
- All overseas documents must be certified by a Notary Public of the country where the documents were produced.
- All documents must be in English. Any documents in foreign languages must be officially translated to English by a certified translator/interpreter.
- Please provide the following documents (where applicable):
 - Copy of the Inpatient Discharge Summary
 - Copy of any diagnostic reports, radiology, X-ray reports, laboratory evidence and any relevant hospital reports
 - Copy of final hospital/medical invoices and receipts (interim invoices are not acceptable)
 - Copy of claim settlement letter if there was reimbursement of medical expenses from another insurance policies (if any)
 - 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)
- 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.
- 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:		
<input type="checkbox"/> Annuity Medical	<input type="checkbox"/> Biennial Medical	
<input type="checkbox"/> Health Screening	<input type="checkbox"/> Hospitalisation / Day Surgery / Other Medical Benefit	
Section A: Details of Life Assured and Assured		
Details of Life Assured		
Name of Life Assured	NRIC / FIN / Passport / Birth Certificate Number	
Occupation	Date of Birth (dd/mm/yyyy)	Gender
Details of Assured		
Name of Assured	NRIC / FIN / Passport Number	
Email	Contact Number	
Residential Address *		
Postal Code		
Country		
<p>* Note: All communication will be sent to the contact information (address, email or phone number) registered with us. Please log into https://mysinglife.singlife.com/account/login to update your contact details if there are any changes.</p>		

Details of Illness / Injury

1) Date symptoms **first** started (dd/mm/yyyy)

2) Describe all the symptoms presented.

3) Date **first** consulted doctor for the condition (dd/mm/yyyy)

4) Details on the Bills / Receipts (applicable for Annuity Medical / Biennial Medical / Health Screening Benefits Only)

Date on Bills / Receipts Incurred (dd/mm/yyyy)	Type / Description of Consultation / Check-up	Name(s) of Doctor(s)	Name(s) and Address(es) of Clinic(s)

5) Name and address of the **first** doctor 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) provided to the Life Assured?					
12) Name and address of doctor / specialist who attended to the Life Assured during hospital confinement					
13) Name and address of all doctor(s) consulted for the condition					
14) Name(s) and address(es) 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 condition(s):					
15) Is the Life Assured claiming / intending to claim for medical expenses from any other insurance company(ies) or other sources i.e. employer, Work Injury Compensation Act (WICA) and etc? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "Yes", please provide the details below and the claim settlement letter from the other party.					
Name of Insurance Company / Other Sources	Policy Number	Type of Plan	Date of Issue (dd/mm/yyyy)	Claim Amount	Claim Settled (Yes / No)
If the illness/injury resulted from an accident, please complete this section.					
1) Place & Country of Accident					
2) Date of Accident (dd/mm/yyyy)			3) Time of Accident (time)		
4) Describe and provide details on how the accident happened.					
5) Exact area(s) of the body affected by injury/disability and extent of injuries/disabilities sustained.					
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 ensure that you have registered for PayNow using your NRIC/FIN.					
Section C: Declaration of Beneficial Owner					
Note: This is only applicable if the recipient of the proceeds is a legal person or a legal arrangement.					
<input type="checkbox"/> 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.					

Section D: Declaration and Authorisation

Name of Life Assured	NRIC / FIN / Passport / Birth Certificate Number
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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 am/We 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:

- 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.
- 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.
- 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.
- 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:

- 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.
- 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 whose information you have disclosed.
- If the Assured has been assessed by a doctor to lack mental capacity*, the Assured's appointed Donee(s)/Deputy(s), or Next of Kin if a Donee(s)/Deputy(s) has not been appointed, is to complete this section and sign. The mentally incapacitated Assured need not sign off/affix thumbprint.

*A separate doctor's memo should be submitted to indicate that the Assured lacks mental capacity, including the relevant medical reason(s).

Signature / Thumbprint / Company's Stamp (if applicable)	Date (dd/mm/yyyy)
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Name of Assured

NRIC / FIN / Passport Number

Signature of Life Assured aged 21 Years or above (if different from Assured)	Date (dd/mm/yyyy)
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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 Number:	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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide more details:		<input type="checkbox"/> Pregnancy or Childbirth <input type="checkbox"/> Abortion or Miscarriage <input type="checkbox"/> Infertility or Sub-fertility Condition <input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> Congenital Anomaly <input type="checkbox"/> Genetic or Chromosomal Disorder <input type="checkbox"/> Mental or Psychiatric Condition <input type="checkbox"/> 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 when the condition is likely to have first existed.: (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 were no symptoms 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) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not to my knowledge			
15) Was the patient referred to you by another doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide a copy of the referral letter and the following information: <u>Name of Doctor</u> <u>First Consultation Date</u> <u>Name of Clinic</u> <u>Address</u>			
16) Did the patient ever consult any other doctor(s) previously for the above condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not to my knowledge If "Yes", please provide the following information: <u>Name of Doctor</u> <u>First Consultation Date</u> <u>Name of Clinic</u> <u>Address</u>			
17) Please provide us with the patient's regular doctor's name, clinic and address. <u>Name of Doctor</u> <u>Reason for consultation(s)</u> <u>Name of Clinic</u> <u>Address</u>			
18) Is the patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please state the estimated duration for which the patient needs to continue follow-up with you. If "No", please state 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please state the medical condition(s) and the date of diagnosis:			
21) Please state the surgical procedure(s) performed. If there was no surgical procedure, please state the treatment / medication given.		22) If surgical procedure(s) was performed, please provide the following: <u>Surgical Procedure Code</u> <u>Date (dd/mm/yyyy)</u> <u>Name of Surgeon</u>	
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)	