

Dear Claimant

We are sorry to learn of your illness/ injury.

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

1. **Critical Illness** Form
2. Attending Physician's Statement
3. **Original** Policy Document
4. Copy of the Life Insured's/Payor's (for Payor Benefit)/ Child (For Serious Illness of a Child Benefit) Identity Card/Birth Certificate/ Passport
5. Copy of the policyholder's Identity Card/Passport, if different from Life Insured
6. **Proof of Relationship for Payor Benefit claims** e.g. Certificate of Marriage, Certificate of Registration of Birth
7. All available **Laboratory and Test Results** (as specified on the Attending Physician's Statement)
8. Upon receipt of **ALL** the above required documents, we will process your claim and inform you of the outcome as soon as possible. However, in certain circumstances, we may require further information after the above documents are received.
9. If you need any assistance, please contact our Client Services Officers at **6833 8188**

Notes:

- I. Please note that the fee for completing the Attending Physician's Statement shall be borne by the life insured/ policyowner.
- II. If you are asking another party to handle the claim process on your behalf, an authorisation letter is required.
- III. Please continue to pay the premiums until the claim is approved.
- IV. If the policy has a nomination under section 73 of the Conveyancing and Law of Property Act, **the proceeds will be payable to the trustee for the benefit of the beneficiary(ies).**
- V. If the policy has a nomination under section 49L of the Insurance Act, **the proceeds will be payable to the trustee of the policy for the benefit of the beneficiary(ies).** If the sole trustee is the policyholder, we are unable to make payment to the policyholder. In this instance,, the policyholder can either appoint another trustee by using a prescribed form to receive the proceeds for the benefit of the beneficiary(ies) or give us instructions to make payment to each beneficiary for his/ her share.

Notes:

- (1) The issue of this form or any other form(s) does not represent any admission of liability by Manulife (Singapore) Pte Ltd ("Company").
- (2) This form has to be signed by the life insured and the policyholder.
- (3) For Payor Benefit claim, please fill up the details of the Payor at Sections 2 to 6.
- (4) For Serious Illness of a Child Benefit claim, please fill up the details of the Child at Sections 2 to 6.
- (5) If the life insured/payor/child (as the case may be) is less than 16 years old, only the signature of the policyholder is required.

Policy No. _____

Claim No.
(For internal use)**1. PERSONAL PARTICULARS OF POLICYHOLDER**

Name: _____ NRIC No/ Passport : _____
Date of Birth: _____ Age: _____ Sex: _____ Tel (O): _____
Address: _____ Tel (H): _____
_____ Mobile: _____
Present Occupation: _____

2. PERSONAL PARTICULARS OF LIFE ASSURED (if different from above)

Name: _____ NRIC No/ Passport : _____
Date of Birth: _____ Age: _____ Sex: _____ Tel (O): _____
Address: _____ Tel (H): _____
_____ Mobile: _____
Present Occupation: _____

3. DETAILS OF ILLNESS

(a) Name of critical illness: _____

(b) Describe in detail all symptoms and/or nature of Life Insured's illness.

(c) Date when Life Insured first experienced these symptoms: _____ / _____ / _____
day month year

(d) How long had the Life Insured been having these symptoms before he/she consulted a doctor?

(e) Date when Life Insured first consulted a doctor for these symptoms: _____ / _____ / _____
day month year

(f) What was the diagnosis?

(g) Has the Life Insured previously suffered from or received treatment for a similar or related illness?

Yes No

If "Yes", please provide the details.

4. RECORD OF MEDICAL CONSULTATIONS

Please provide the names of the doctors Life Insured had consulted in relation to the illness at paragraph 3(a) and the addresses of the respective hospitals / clinics.

Name of Doctor	Name/ Address of Hospital/ Clinic	Dates of First Consultation

Details of the name(s) and address(es) of the doctor(s) Life Insured saw most of the time when Life Insured is sick.

Name of Doctor	Address	Telephone No. / Fax No.

5. GENERAL

Have any of the Life Insured's blood relatives suffered from a similar or related illness? Yes No

If "Yes", please provide us the following details.

Relationship of Relative	Nature of Illness	Date Illness First Diagnosed

Does the Life Insured smoke? Yes No

If "Yes", please provide us the following information.

(i) How many cigarettes does the Life Insured smoke per day? _____

(ii) For how long has the Life Insured been smoking? _____

Does the Life Insured consume alcohol? Yes No

If "Yes", please provide us the following information.

(i) Type of alcohol: _____

(ii) Quantity consumed per day: _____

5. OTHER INSURANCE(S)

Are there any claims submitted or to be submitted to any other insurance company in respect of this critical illness?

Yes No

If "Yes", please provide the following information:

Name of Insurer	Policy No.	Policy Effective Date	Type of Plan	Sum Assured	Claim Amount	Claim Notified (Yes/No)

DECLARATION AND AUTHORISATION

I **declare** that all answers given by me in this form are, to the best of my knowledge and belief, true and complete.

I **consent** to the Company seeking / providing information about me from / to any medical source, insurance office, organisation or person, governmental organisation and / or regulatory body. **A photographic copy of this authorisation shall be as valid as the original.**

I **agree** to bear the fees (if any) payable for any reports obtained for the purpose of processing of this claim. I understand that these reports may not be made available to me and that the Company reserves the right not to release these report(s) or a copy of these report(s) to me. I **give** my consent for the fees to be deducted from the claim that is payable to me, if it is admitted.

Signature of Life Insured / Payor/ Child

Name (as per NRIC):

Date:

Signature of witness

Name (as per NRIC):

NRIC/PP No.:

Contact No.:

Date:

Signature of Policyholder (if different from Life Insured)

Name (as per NRIC):

Date:

Signature of Witness

Name (as per NRIC):

NRIC/PP No.:

Contact No.:

Date: