

Dear Claimant

1. We are sorry to learn of the life insured's medical condition and/or hospitalisation.
2. In order for us to process the claim, we require the following shown below for the respective medical claim:

#### DOCUMENTS REQUIRED FOR CLAIM SUBMISSION

MEDICASH / HOSPITAL BENEFIT CLAIM	MANUCARE CLAIM / HOSPITAL & SURGICAL RIDER CLAIM
<p>a). <b>Medical Claim Form</b> to be fully completed by Claimant (Part A) and Attending Physician (Part B)</p> <p><i>Please note that the fee for completion of the Attending Physician's Statement shall be borne by the policyowner.</i></p>	<p>a) <b>Medical Claim Form</b> to be fully completed by Claimant (Part A) and Attending Physician (Part B).</p> <p><i>Please note that the fee for completion of the Attending Physician's Statement shall be borne by the policyowner.</i></p>
<p>b) We may waive the Attending Physician's Statement (APS) if the <b>claim amount is less than S\$1,500 and/or the hospitalization is less than 5 days. However, we require either an "Inpatient Discharge Summary" or Doctor's Memo</b> to be submitted together with the claim.</p> <p><b>The Company reserves the right to ask for APS if deem necessary. The cost of obtaining the APS is at policyowner's own expense.</b></p>	<p>b) We may waive the Attending Physician's Statement (APS) if the <b>claim amount is less than S\$1,500 and/or the hospitalization is less than 5 days. However, we require either an "Inpatient Discharge Summary" or Doctor's Memo</b> to be submitted together with the claim.</p> <p><b>The Company reserves the right to ask for APS if deem necessary. The cost of obtaining the APS is at policyowner's own expense.</b></p>
<p>c) Photocopy of the Original Hospital Bills/ Medical Certificates</p>	<p>c) <b>Final &amp; Original Hospital Bills, itemized hospital bills and receipts including Medical Certificates <u>must be submitted.</u></b> If you are claiming from another insurer, please submit a <b>certified true copy</b> of all the original final bills, reports &amp; final approval letter of the insurer.</p>
<p>d) <b>Submission of claim documents</b> Please submit all claim documents through your representative or directly to Manulife (Singapore) Pte Ltd.</p>	<p>d) <b>Submission of claim documents</b> Please submit all claim documents through your representative or directly to Manulife (Singapore) Pte Ltd.</p>

3. 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.
4. If you need any assistance, please contact our Client Services Officers at **6833 8188**.

#### NOTES:

Please note that Hospital Benefit, Hospital & Surgical Rider and Medicash are riders attached to base plan. Hence, if you have made a nomination under section 73 of the Conveyancing and Law of Property Act or section 49L of the Insurance Act, the nomination on the base plan will apply similarly to the rider. Payment will be made to the trustee for the benefit of the beneficiary(ies). For a nomination under section 49L, payment cannot be made to a trustee who is also the policyowner and sole trustee. In such instance, the policyowner can either appoint another trustee to receive the payment or instruct us to make payment to each beneficiary for his/her share.

## MEDICAL CLAIM FORM PART A - CLAIMANT'S STATEMENT

Please tick (✓) the box where appropriate.

- Manucare  
 Mediacash Benefit  
 Hospitalisation Benefit  
 Surgical Benefit

**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 should be **signed by the life insured and the policyowner**. If the life insured is below 16 years, the policyowner or parent or legal guardian is to sign for the child.
- (3) The life insured is to complete Nos. 2 to 7 on the details of hospitalization claim for assessment.

Policy No.

Claim No.  
(For internal use)

### 1. PERSONAL PARTICULARS OF POLICYOWNER

Name: \_\_\_\_\_ NRIC No/ Passport : \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Tel: \_\_\_\_\_

Address: \_\_\_\_\_ Marital Status: \_\_\_\_\_

\_\_\_\_\_ Current Occupation: \_\_\_\_\_

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

Name: \_\_\_\_\_ NRIC No/ Passport : \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Tel: \_\_\_\_\_

Address: \_\_\_\_\_ Marital Status: \_\_\_\_\_

\_\_\_\_\_ Current Occupation: \_\_\_\_\_

### 3. DETAILS OF HOSPITALISATION

(a) Full name and address of Hospital in which the Life Insured is confined with respect to this claim:

\_\_\_\_\_

\_\_\_\_\_

(b) Is this hospital outside of Singapore?  Yes  No

If the hospital is outside of Singapore, please indicate how long you have been away from Singapore (from the time the Life Insured left Singapore till the hospitalisation is completed)

From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

dd mm yyyy dd mm yyyy

(c) Name of the Attending Physician / Doctor (s): \_\_\_\_\_

(d) Date(s) and Period(s) of:

(1) Hospitalisation From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy dd mm yyyy

(2) Intensive Care From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy dd mm yyyy

(e) How was the Life Insured admitted to the hospital? (Please tick ✓)

Referral by a General Practitioner/ Specialist / Other Hospital \* (\*please delete accordingly)

Please provide details. \_\_\_\_\_

A & E department – The health condition at admission: \_\_\_\_\_

#### 4. MEDICAL CONDITION

(a) Describe in detail the symptoms for which the life insured consulted a doctor

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(b) When did the symptoms first appear?

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

(c) When did the Life Insured first consult a doctor?

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

Name and address of the doctor whom the life insured **first consulted** for the illness or injury

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(c) Describe fully the extent and nature of the illness or injury

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(d) What is the hospital/ doctor's diagnosis?

\_\_\_\_\_  
\_\_\_\_\_

(e) Nature of Treatment/ Surgery

\_\_\_\_\_  
\_\_\_\_\_

(f) Date of Treatment/ Surgery

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

(g) Has similar condition occurred in the past?  Yes  No

If "Yes", please provide name and address of the doctor whom the life insured had previously consulted for the illness or injury.

\_\_\_\_\_  
\_\_\_\_\_

(h) Details of Follow-up Consultations on the above condition

Dates(s)	Details of Consultation	Name(s) and Address(es) of Doctor

**5. ACCIDENT (IF APPLICABLE)**

(a) Date of accident \_\_\_\_/\_\_\_\_/\_\_\_\_ (b) Time of accident: \_\_\_\_\_  
                                  dd      mm      yyyy

(c) Place of accident: \_\_\_\_\_  
\_\_\_\_\_

(d) Please describe in detail how the accident happened.  
\_\_\_\_\_  
\_\_\_\_\_

(e) Were there any eye-witnesses to the accident?  Yes  No

If "Yes", please provide the name(s) and address(s) of witness(es).

Name of Witness	Address	Specify Relationship with Life Insured if so

(f) Was the accident reported to the police?  Yes  No

If "Yes", please provide us with the name of the police station at which the accident was reported and the police report. If "No", please provide reason why not.

\_\_\_\_\_  
\_\_\_\_\_

**6. DETAILS OF REGULAR DOCTOR (S)**

Details of the name(s) and address(es) of the doctor(s) Life Insured **saw most of the time (whether for the claimed condition or for other conditions)**

Name of Doctor(s)	Address(es)	Tel No. / Fax No.	Reason for Consultation

**7. OTHER INSURANCE(S)**

Is there any claim submitted or to be submitted to any other insurance company or other sources (e.g. employer, other insurances including Medishield, Medisave-approved Integrated Shield Plans) in respect of this hospitalization?  Yes  No

If "Yes", please provide the following information and a copy of the respective payment/ benefit schedule.

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

**DECLARATION AND AUTHORISATION (By both life insured and policyowner)**

I **declare** that all answers provided 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** that the fees (if any) payable for any reports obtained for the purpose of processing of this claim are to be borne by the policyowner. The Company can also deduct the fees from the claim (if admitted). 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.

**Signature of Life Insured / Parent or Legal Guardian of Child**

**Signature of witness**

\_\_\_\_\_  
Name (as per NRIC):  
Date:

\_\_\_\_\_  
Name (as per NRIC):  
NRIC/PP No.:  
Contact No.:  
Date:

**Signature of Policyowner (if different from Life Insured)**

**Signature of Witness**

\_\_\_\_\_  
Name (as per NRIC):  
Date:

\_\_\_\_\_  
Name (as per NRIC):  
NRIC/PP No.:  
Contact No.:  
Date:

**Notes:**

- (1) The fee for this report is to be paid by the policyowner.
- (2) Please return the completed Attending Physician's Statement with all relevant tests, Histological reports, CT Scan, etc to:

Manulife (Singapore) Pte Ltd.  
 51 Bras Basah Road  
 #09-00, Manulife Centre  
 Singapore 189554  
 Attention: Claims Department

Policy No.
Claim No. <small>(For internal use)</small>

**PATIENT'S PARTICULARS**

Name: \_\_\_\_\_ NRIC No/ Passport : \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation (if known): \_\_\_\_\_ Sex: \_\_\_\_\_

1. Has the patient consulted any other doctor(s)/ hospital(s) prior to first consultation with you?  Yes  No

If "Yes", please provide the name and address of the doctor(s)/ hospital(s).

\_\_\_\_\_

\_\_\_\_\_

a) Are you the patient's usual medical doctor?  Yes  No

If "Yes", since when? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

2. Date of first consultation for the current condition: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

a) Please state symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date symptoms first started (dd/mm/yyyy)

b) What was your diagnosis? \_\_\_\_\_

\_\_\_\_\_

c) Date of diagnosis: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

d) Date diagnosis was made known to the patient: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy



c) Was the patient under the influence of alcohol?  Yes  No

If "Yes", what was the blood alcohol content and the reading?

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d) Was the patient under the influence of any drugs?  Yes  No

If "Yes", please provide the name of drugs and results of any blood tests performed

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e) Was the accident reported to the police?  Yes  No

If "Yes", please provide us with the name of the police station at which the accident was reported and the police report. If "No", please provide reason why not.

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f) In your opinion, were the injuries sustained caused solely by the accident and not related to other causes?

Yes  No

If "No", what had contributed directly or indirectly to the patient's injuries?

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6. Please state the periods of hospitalisation

Name of Hospital	Period(s) of Hospitalisation		Period(s) of Intensive Care	
	From	To	From	To

7. Treatment

a) Please tick if the following were done / will be done.

- Medical       Cancer Treatment       Kidney Dialysis       Organ Transplant

Please provide details including date done or expected to be done and why is it necessary.

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b) **For female only:** Was the patient pregnant at time of hospitalization?       Yes       No

If "Yes", for how many months? \_\_\_\_\_

c) Is the current treatment associated with the following: -

- |  |                          |     |                          |    |
|--|--------------------------|-----|--------------------------|----|
| (i) Pregnancy, childbirth or miscarriage or complications from pregnancy or childbirth                                 | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (ii) Prenatal or postnatal care  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (iii) Birth control/ Sterilisation   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (iv) Infertility/ Subfertility   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (v) Abortion   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (vi) Routine health check-up   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (vii) Dental care or surgery   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (viii) Alcoholism  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (ix) Drug addiction or abuse   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (x) Mental or nervous disorder or "rest cures"   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (xi) Birth defects   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (xii) Hereditary conditions  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (xiii) Congenital sickness or abnormalities  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (xiv) Obesity, weight reduction or weight improvement  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| (xv) Sexually-transmitted disease, AIDS or any illness caused by or related to the Human Immuno-deficiency Virus (HIV) | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

If you have ticked "Yes" to any of the above boxes, please provide details.

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d) Is the patient still on follow-up treatment?       Yes       No

If "yes", please specify the type of treatment/ medication.

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e) How frequent does the patient seeks treatment since discharge from hospital?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

f) What is the expected length of follow-up?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Surgery

a) Was surgery performed for this condition?  Yes  No

If "Yes", please specify.

Nature of Surgical Operation(s)	Date(s) performed (dd/mm/yyyy)

b) Is the surgery performed an elective or plastic surgery?  Yes  No

If "Yes", please provide details.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c) Is further surgery likely to be required?  Yes  No

If "Yes", please state tentative date of surgery:    \_\_\_/\_\_\_/\_\_\_  
  dd    mm    yyyy

9. Medical History

a) Has the patient previously suffered from the same illness in respect of which he/ she is claiming now?  Yes  No

If "Yes", please state:

(i) Date when illness was first diagnosed: \_\_\_/\_\_\_/\_\_\_  
  dd    mm    yyyy

(ii) Name and address of the doctor who first treated him/ her

\_\_\_\_\_  
\_\_\_\_\_

b) Has the patient been admitted to any hospital before, either for the same or different cause? If "yes", please provide details below.  Yes  No

Period(s) of Hospitalisation	Diagnosis	Hospital	Name(s) and Address(es) of Attending Doctor

c) Is the patient suffering or has suffered from any other significant illnesses?  Yes  No

Description of Illness(es)	Date(s) of Consultations (dd/mm/yyyy)	Name(s) and Address(es) of Attending Doctor

10. Please provide us any other additional information that will enable the Company to assess this claim.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. Please **enclose copies of specialist or hospital reports together with any tests** or similar evidence to support the validity of the patient's claim.

**Signature of Doctor**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Name and Qualification (printed)**

\_\_\_\_\_

**Address & Official Stamp**

\_\_\_\_\_