

This form must be completed by the insured person or claimant on behalf of minor dependents and sent to **MANULIFE (SINGAPORE) PTE LTD** with all required medical information and documentation. Failure to submit a complete claim with all supporting medical information will result in returning the claim to you. Additional claim forms may be requested as needed.

The Insurer does not admit liability by the mere issue of this form.

PART I CLAIMANT'S INFORMATION

Policy No:	Benefit Type:	Bronze		Silver		Gold		Platinum	
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1. Name of Insured	:	_____	4. NRIC/PP No.	:	_____
2. Date of Birth	:	_____	5. Sex	:	_____
3. Mailing Address	:	_____	6. Tel (Home)	:	_____
		_____	7. Tel (Office)	:	_____

8. Dependent's Name (If claim is a dependent)	:	_____	Relationship to Insured	:	_____
			Date of Birth	:	_____

PART II CLAIMS DETAILS – ALL QUESTIONS BELOW MUST BE ANSWERED

1. Which Recovery Benefit Are You Claiming?	_____
2. If Your Claim Results From An Accident:	(a) Date Accident Occurred: _____ (b) Nature of Injury: _____
3. If Your Claim Results From An Illness, When Were Your First Diagnosed As Suffering The Illness?	_____
4. When Were You Advised To Be Treated In Hospital?	_____
5. When Were You First Admitted To Hospital?	_____
6. When Were You Discharged From Hospital?	_____
7. Please Provide Time, Name & Address Of The Hospital Doctor We Can Contact To Validate Your Claim.	_____

Note: Your claim will be processed quickly if you can attach a copy of your hospital In-patient Discharge Summary form which confirms your hospital treatment.

DECLARATION AND AUTHORISATION

I/We jointly certify that the above information is true and correct to the best of my/our knowledge. I/We hereby authorise any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, or employer having information available as to diagnosis, treatment, or prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me and my minor children to give to **MANULIFE (SINGAPORE) PTE LTD**.

I/We understand the information obtained by the use of this Authorization will be used by **MANULIFE (SINGAPORE) PTE LTD** to determine eligibility for benefits under the policy. Any information obtained will not be released to any person or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I or my authorized representative is entitled to receive a copy of this Authorization. I agree that a photographic copy of this Authorization is as valid as the original and that it shall be valid until the final disposition of the claim to which it relates.

_____	_____	_____
Signature of Insured Person	Date	* Dependent's Signature

* Dependent's Signature is Required if claim is on Spouse or Dependent Child over age 21.

Your physician is required to assist your claim by completing the reverse side.

ATTENDING PHYSICIAN'S INFORMATION

Note to Physician : Completing this information will help to expedite the processing of your Patient's claim. Please understand that all benefits under the Recovery Plus Rider are paid directly to the insured person and amounts payable are based upon a pre-defined schedule.

Patient's Name : _____	NRIC / PP No : _____
Physician's Name : _____	Hospital Name : _____
Address : _____	Telephone No : _____

Date of Patient's Illness (1 st symptom) or Injury (accident) :	Date of Patient first consulted you for this condition :	Has Patient ever had the same or similar symptoms? : Yes <input type="checkbox"/> No <input type="checkbox"/>
If YES, please provide details:		
<u>Dates</u>	<u>Condition</u>	<u>Treatment</u> <u>Doctor's/Hospital's Name</u>

Diagnosis or Nature of Illness or Injury :

What procedure(s) were undertaken whilst the patient was hospitalised?

Was the patient referred to you by another physician? Yes No If YES, please provide the name and address.

Physician's Name : _____ Telephone No : _____

Address : _____

Please provide details of the Doctor that originally referred the Patient to commence your Doctor/Patient relationship (if applicable) :

Date Patient admitted to hospital : _____ Date Patient discharged from hospital : _____

Has this Patient sought and obtained consultation in the last year? Yes No

If YES, please provide details of consultation and treatment.

<u>Dates</u>	<u>Consultation</u>	<u>Details of Treatment / Hospitalisation</u>	<u>Doctor's / Hospital's Name</u>
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For Female Only: Was the patient pregnant at the time of hospitalisation? Yes No If YES, for how many months? _____

Signature : _____ Name of Physician : _____ MCR No. : _____ Qualification : _____ Date : _____	Practice Stamp & Address : <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
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