

Dear Claimant

We are sorry to learn of the life insured's condition under the Special Benefit.

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

1. **Special Benefit Claim Form**
2. Attending Physician's Statement
3. **Original** Policy Document
4. Copy of the policyowner's Identity Card/Passport
5. Copy of the Life Insured's Identity Card/Birth Certificate/ Passport, if different from policyowner's.
6. All available **Laboratory and Test Results** (as specified on the Attending Physician's Statement)
7. 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.
8. If you need any assistance, please contact our Customer Service 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 assist in the claim processing, 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 policyowner, we are unable to make payment to the policyowner. In this instance,, the policyowner 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 should be completed by the Claimant. (Life Insured or Policyowner as the case may be.)

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

**1. PERSONAL PARTICULARS**

Name of Life Insured: \_\_\_\_\_ NRIC No: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Tel (O): \_\_\_\_\_ Tel (H): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Occupation: \_\_\_\_\_

**2. TYPE OF SPECIAL BENEFIT**

Please indicate the type of benefit you would like to claim by ticking the appropriate box.

**(a) Mum@myfuture Plan**

- |  |   |
|--|---|
| <input type="checkbox"/> Termination of Pregnancy<br><input type="checkbox"/> Stillbirth<br><input type="checkbox"/> Congenital Anomaly <ul style="list-style-type: none"> <li><input type="radio"/> Down's Syndrome</li> <li><input type="radio"/> Spina Bifida</li> <li><input type="radio"/> Tetralogy of Fallot</li> <li><input type="radio"/> Neonatal Death</li> </ul> | <input type="radio"/> Oesophageal Atresia and Oesophago Tracheal Fistula<br><input type="radio"/> Hydrocephalus |
|--|---|

**(b) Him@myfuture Plan**

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|---|---|
| <input type="checkbox"/> Prostate Cancer<br><input type="checkbox"/> Open Surgery for Kidney Stones | <input type="checkbox"/> Liver Cancer<br><input type="checkbox"/> Lung Cancer |
|---|---|

**(c) Her@myfuture Plan**

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|--|--|
| <input type="checkbox"/> Carcinoma-in-situ Benefit <ul style="list-style-type: none"> <li><input type="radio"/> Re-constructive Surgery Benefit</li> <li><input type="radio"/> Major plastic surgery due to accidents</li> <li><input type="radio"/> Skin transplantation due to accidental burning</li> </ul> | <input type="checkbox"/> Menopause Complication Benefit <ul style="list-style-type: none"> <li><input type="radio"/> Dilatation and Curettage</li> <li><input type="radio"/> Hysterectomy</li> </ul> |
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**(d) Kid@myfuture Plan**

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|---|--|
| <input type="checkbox"/> Kawasaki Disease                           | <input type="checkbox"/> Haemophilia A and Haemophilia B |
| <input type="checkbox"/> Rheumatic Fever with Valvular Impairment   | <input type="checkbox"/> Leukaemia                       |
| <input type="checkbox"/> Insulin Dependent Diabetes Mellitus (IDDM) | <input type="checkbox"/> Bone Marrow Transplant          |
| <input type="checkbox"/> Osteogenesis Imperfecta                    |  |

**(e) Premier Lady Plan**

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|---|---|
| <input type="checkbox"/> Carcinoma-in-situ Benefit                          | <input type="checkbox"/> Re-constructive Surgery Benefit        |
| <input type="checkbox"/> Congenital Anomaly Benefit                         | <input type="radio"/> Major plastic surgery due to accidents    |
| <input type="radio"/> Down's Syndrome                                       | <input type="radio"/> Skin transplant due to accidental burning |
| <input type="radio"/> Spina Bifida  | <input type="checkbox"/> Pregnancy Complications                |
| <input type="radio"/> Tetralogy Fallot                                      | <input type="radio"/> Disseminated Intravascular Coagulation    |
| <input type="radio"/> Oesophageal Atresia and Oesophago<br>Tracheal Fistula | <input type="radio"/> Ectopic Pregnancy                         |
| <input type="radio"/> Hydrocephalus   | <input type="radio"/> Hydatidiform Mole                         |
| <input type="radio"/> Neonatal Death  | <input type="radio"/> Postpartum Psychosis                      |
|   | <input type="radio"/> Still Birth                               |

**3. DETAILS OF ILLNESS**

Please provide information to the following questions where applicable.

(a) Date on which the first symptoms appeared: \_\_\_\_\_

(b) Describe all the symptoms and/ or the nature of the medical condition.

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

(c) Date of Diagnosis: \_\_\_\_\_

(d) The name and address of a medical practitioner you first consulted for this illness.

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

(e) How long have you been having these symptoms from the date of your first consultation?

\_\_\_\_\_

(f) Have you previously suffered from, or received treatment for, a similar or related illness? If yes, please give full details:

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

(g) If you are claiming for **Menopause Complication Benefit**, please complete the following.

(i) What is the cause of the claimed condition?

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(h) If you are claiming for **Re-constructive Surgery Benefit**, please complete the following.

(i) What is the reason for this re-constructive surgery?

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(ii) Date of the accident or assault: \_\_\_\_\_

(iii) Brief description of accident or assault.

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(iv) Was a police report made? (If yes, please attach a copy of the report.)  Yes  No

(v) Please describe the part(s) of the body structures affected.

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#### 4. RECORD OF MEDICAL CONSULTATIONS/ HOSPITALISATION

(a) Details of any Physician(s) or Specialist(s) who have been consulted for the illness

Name(s) Address(es) Date of consultation

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(b) Details of any Hospitalisation in connection with the illness

Name(s) Address(es) Date of consultation

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**5. GENERAL**

(a) Have any of your blood relatives suffered from a similar or related illness? If yes, please complete the following:

<u>Relationship to Claimant</u>	<u>Nature of Illness</u>	<u>Date First Diagnosed</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**6. OTHER INSURANCES**

(a) Are you claiming from any other insurance company in respect of this illness? If yes, please provide the following information.

<u>Name of Insurer</u>	<u>Policy Number</u>	<u>Amount to be Claimed</u>	<u>Date of Submission</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**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 Claimant**

**Signature of Witness**

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

Date:

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

NRIC/ PP No:

Contact No:

Date: