

Dear Claimant,

We are sorry to learn of your accident/illness.

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

1. Completed Accident and Health Claim Form.
2. Hospital discharge summary, doctor's memo, medical report, MRI/X-ray results or Attending Physician's Statement (APS) to support the diagnosis.
3. Final hospital/clinic bills:
  - For bills that indicate any payment by CPF MediSave and/or CPF MediShield Life, please provide statement from CPF Board showing the deductions and Hospital Registration/Reference Number.
  - For bills from Traditional Chinese Medicine (TCM) or Chiropractic clinics, please ensure that the practitioner's name is indicated on the bills.

(Do not submit original bills. However, keep the originals for 6 months from the submission date as we may require you to provide them to us.)

4. Medical certificates if claiming weekly indemnity (i.e. medical leave).
5. Child's birth certificate if claiming Baby Bonus Benefit.
6. Policy Owner's bank statement or passbook with name & account number if preferred payment is Electronic Fund Transfer (EFT) to a Singapore bank account, if an existing EFT has not been set up for the same bank account.
7. Police report (if any).

To avoid any delay in processing your claim, please ensure that all required documents are completed and submitted. We may require further information/document(s) from you in certain circumstances.

**Notes:**

- I. The fee for obtaining the hospital discharge summary, doctor's memo, medical report, MRI/X-ray reports or Attending Physician's Statement shall be borne by the Policy Owner.
- II. All documents in foreign languages must be officially translated to English by a certified translator/interpreter.

**Online submission**

We encourage you to submit your claim to us via our online **eClaim platform** at [www.manulife.com.sg/en/self-serve/file-a-claim.html](http://www.manulife.com.sg/en/self-serve/file-a-claim.html). This will help us process your claim more swiftly. There is no need to complete this claim form if you are submitting the claim online.

**Manual submission**

You may submit the completed and signed form with all relevant documents to us through any of the following modes:  
**Email – SGP\_A&Hclaims@manulife.com**  
**Mail – 8 Cross Street #15-01, Manulife Tower, Singapore 048424**

**Need Help?**

Please contact your **Financial Representative** if you require assistance. Alternatively, you may email us at [service@manulife.com](mailto:service@manulife.com) or call our Client Service Officers at 6833 8188.

**INTERNAL USE - FOR STAFF**

If there is a follow-up claim number, do not create a claim number.

Follow-up Claim No. ....

Policy No. ....

Claim Type       CL-105       CL-106       CL-107

No. of pages      .....      Date .....

AHCF-1221-3

**Please note that:**



1. The mere issue of this form or any other form(s) does not represent any admission of liability by Manulife (Singapore) Pte. Ltd.
2. This form is to be completed by the Policy Owner, or a Financial Representative on behalf of the Policy Owner.
3. You will receive the outcome of your claim within 10 working days.

**BEFORE** you submit this claim form, do ensure your latest mailing address, mobile and email have been updated with us. Log in to our secured customer portal, MyManulife, at [www.mymanulife.com.sg](http://www.mymanulife.com.sg) for an immediate update. You will **NOT** receive claim updates if your particulars are outdated.

Alternatively, you may fill in the **Personal Details Update** form and send it to us. Go to [www.manulife.com.sg](http://www.manulife.com.sg) to download this form. This method is **NOT** preferred though, as we will not be able to update your particulars if your signature does not match that in our records. This will cause a delay in the processing of your claim.

## Part 1 POLICY INFORMATION

### A. About the Policy Owner

Policy number(s)	
Full name	
NRIC/Passport number	

### B. Life Insured's Details

Full name (if different from Policy Owner)	
NRIC/Passport no. (if different from Policy Owner)	

**Life Insured's Employment (compulsory to be completed)**

Current employment status	<input type="checkbox"/> Unemployed <input type="checkbox"/> Employed <input type="checkbox"/> Self-employed
Current occupation/title	
Current employer's name	
Current employer's address	
Policy Owner's relationship with the Life Insured	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent

## Part 2 CLAIM DETAILS

What is the cause of this claim?	<input type="checkbox"/> Illness <input type="checkbox"/> Accident <input type="checkbox"/> Baby Bonus Benefit
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### A. Claim details (for illness)

Describe the symptoms	
Doctor's diagnosis	
Date of diagnosis	(DD-MMM-YYYY)

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**B. Claim details (for accident)**

<b>Accident details</b>	
Date of accident (DD-MMM-YYYY) _____	Time of accident <input type="checkbox"/> am <input type="checkbox"/> pm _____ Location of accident _____
<b>Activity Insured was doing at the time of accident</b>	
<input type="checkbox"/> Exercising in a gym <input type="checkbox"/> Running/walking outdoors <input type="checkbox"/> Driving/travelling in a vehicle <input type="checkbox"/> Playing football/soccer <input type="checkbox"/> Playing racquet game/golf <input type="checkbox"/> Swimming <input type="checkbox"/> Carrying out home chores <input type="checkbox"/> Carrying out work duties <input type="checkbox"/> Others (Please specify) _____	
<b>Accident description</b>	
<input type="checkbox"/> Insured fell down <input type="checkbox"/> Insured lifted an object <input type="checkbox"/> Insured collided with someone/an object <input type="checkbox"/> Insured suffered a blow/impact from an external object <input type="checkbox"/> Others (Please specify) _____	
<b>Injury description</b>	
<input type="checkbox"/> Fracture <input type="checkbox"/> External wound like cuts/bruises <input type="checkbox"/> Food poisoning <input type="checkbox"/> Others (Please specify) _____	
Was TCM Practitioner or Chiropractor consulted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of TCM Practitioner or Chiropractor _____	
Was any imaging test (such as X-ray or MRI) done?	<input type="checkbox"/> Yes <input type="checkbox"/> No <span style="float: right;">If yes, please provide report.</span>
Was there a diagnosis of gastroenteritis or stomach flu?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was the insured pregnant when the accident happened?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Was the accident reported to police?	<input type="checkbox"/> Yes <input type="checkbox"/> No <span style="float: right;">If yes, please provide police report.</span>
Additional details you may wish to provide on the accident	

**C. Details of any hospitalisation or medical leave**

Was a day surgery performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of day surgery	(DD-MMM-YYYY)
Was the Insured hospitalised?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Period of hospitalisation	From _____ to _____ (DD-MMM-YYYY)
	From _____ to _____ (DD-MMM-YYYY)
Was medical leave taken due to this incident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Period of medical leave	From _____ to _____ (DD-MMM-YYYY)
	From _____ to _____ (DD-MMM-YYYY)
Has the insured resumed work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of return to work	(DD-MMM-YYYY)
Were light duties given at work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Period of light duties	From _____ to _____ (DD-MMM-YYYY)
	From _____ to _____ (DD-MMM-YYYY)

**D. Other insurance covering the same plan**

Is this hospitalisation bill partially/fully reimbursed by Integrated Shield Policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <span style="float: right;">If yes, please provide settlement letter.</span>
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Is this claim submitted or to be submitted to other insurer/employer/party?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide settlement letter.
Name of insurer/employer/party		

### Part 3 PAYOUT OPTION

By default, we will pay to the Policy Owner’s bank account linked to their PayNow registered with their Singapore NRIC/FIN. If PayNow transaction is unsuccessful because the Policy Owner does not have a PayNow account, or if the PayNow account is registered with a mobile number, we will send a cheque to the Policy Owner’s mailing address as per our record. Register or add Singapore NRIC/FIN to the PayNow account via internet banking or mobile banking application.

**Exceptions to PayNow**

- If the policies have existing Electronic Fund Transfer (EFT) arrangements, the payout will be via EFT.
- If a new EFT arrangement is opted by selecting the EFT option below, the payout will be via EFT.
- If the claim payout exceeds S\$200,000, or it is to a non-Policy Owner, the payout will be via cheque.
- If the policy is subject to a trust created under Section 49L of the Insurance Act (Cap 142), or Section 73 of the Conveyancing and Law of Property Act (Cap 61), both PayNow or EFT will not apply and the payout will be via cheque.

If the Policy Owner does not have an existing EFT arrangement and wish to set up one, tick the option below. This will apply to all future payouts for all policies that qualify for this claim.

**Electronic Fund Transfer (EFT)**

- Please fill in the table below and submit a copy of bank statement OR bank passbook showing account holder’s name & account number.
- This must be a Singapore bank account denominated in Singapore Dollar that belongs to the Policy Owner.

Bank account number	
Bank name	

- If the requirements for EFT are not met, we will send a cheque to Policy Owner’s mailing address as per our record.

### Part 4 DECLARATION & AUTHORISATION BY POLICY OWNER OR CLAIMANT

1. I/We declare, represent and warrant that all answers, information and supporting documents given by me/us in/with this form are, to the best of my/our knowledge and belief, correct, true and complete; and no material information has been withheld nor omitted.
2. I/We consent to Manulife (Singapore) Pte. Ltd. (“Manulife”) seeking/providing information about the life insured and this claim form from/to any medical practitioners, health care providers, insurers, organisations, investigation agencies, governmental organisations, regulators and any other parties in Singapore or any other country for purposes reasonably required by Manulife to process and administer my/our claims (“Purposes”). A photocopy or electronic copy of this authorisation shall be as valid as the original.
3. I/We confirm that I/we have read and understood Manulife Statement of Personal Data Protection which may be amended by Manulife from time to time (“Manulife Statement”). I/We consent to the collection, use, disclosure and processing of my/our, and life insured’s personal data in accordance with Manulife Statement and agree to be bound by Manulife Statement. I/We have obtained a hard copy of Manulife Statement from Manulife and/or downloaded a soft copy of it from [www.manulife.com.sg](http://www.manulife.com.sg).
4. I/We agree that the personal data collected in this form and supporting documents will be used by Manulife for the purpose of complying with my request and other purposes reasonably required by Manulife to process and administer my/our claims.
5. I/We authorise any person, party, organisation, company, corporation, body and partnership, including but not limited to, any medical practitioners, health care providers, insurers, and investigative agencies in Singapore or any other country, to release, disclose or exchange any information (including personal data or personal health information) to or with Manulife for the Purposes.
6. I/We confirm that I/we am/are not an undischarged bankrupt, in winding up, receivership or judicial management and there is currently no pending or threatened bankruptcy or winding up proceeding, receivership or judicial management proceeding against me/us.

7. I/We authorise Manulife to assess the completed claim form and supporting documents received via electronic mail or online portal provided by Manulife ("Electronic Services"). I/We agree that Manulife is not responsible for verifying the authenticity of the instructions given or purported to be given by me/us. Manulife reserves the right (but not obliged) to suspend or disallow the claims processing for verification or other purposes as Manulife deems fit and shall not be liable for any losses incurred in consequence. I/We agree that Manulife shall not be liable for any losses arising from any submissions or instructions lost in transmission whether due to breakdown in the system or otherwise. Manulife retains full authority and discretion to amend the terms and manner of use of the Electronic Services at all times. I/We understand that transmission of submissions or instructions via Electronic Services shall be evidenced by the receipt of a successful message.
8. I/We agree to indemnify and hold harmless Manulife from and against any and all demands, claims, actions, damages, suits proceedings, assessments, judgments, costs, losses (whether direct, indirect, special or consequential) including legal costs, and other expenses arising from or in connection with Manulife accepting and acting on these submissions or instructions (including where relevant, the use of the Electronic Services).
9. I/We am/are aware that this form will not be effective until it is formally accepted and approved by Manulife.
10. If this claim form is submitted by a financial representative or third party on my/our behalf, I/we acknowledge and authorise financial representative or third party to provide the declarations, representations and warranties stated under the Declaration & Authorisation by Financial Representative or Third Party heading on my/our behalf.

I/We confirm and represent that the electronic medical invoice(s) submitted is a true copy issued by the medical institution. I/We understand and agree that I/we can claim or be reimbursed for the medical invoice(s) that I/we have incurred one time only regardless of the number of medical insurance policies I/we may have. I/We will not claim from my/our employer, any other insurer or party for the same medical invoice(s) on the portion that will be reimbursed by Manulife. Otherwise, it may amount to fraud. I/We will keep the original or certified true copy of medical invoice(s) for a period of 6 months from the date of submission, and provide the same to Manulife upon request. I/We agree that Manulife may recover any excess amount paid to me/us.

**Name** .....  
**NRIC/Passport No.** .....  
**Contact No.** .....  
**E-mail** .....  
**Date** ..... (DD-MMM-YYYY)

Signature is not required for this form. By submitting this form to Manulife, the policy owner is deemed to have read, understood and agreed to the terms and conditions stated in this Part 4.

## Part 5 (applicable if financial representative or third party is submitting this claim)

### DECLARATION & AUTHORISATION BY FINANCIAL REPRESENTATIVE OR THIRD PARTY

I declare, represent and warrant that:

- (a) I am completing and submitting this claim form and supporting documents to Manulife (Singapore) Pte Ltd on behalf of the policy owner/claimant based on the instruction, information (including the personal data) and supporting documents provided by the policy owner/claimant;
- (b) to the best of my knowledge and belief, such information and supporting documents stated in subclause (a) above are correct, true and complete;
- (c) the policy owner/claimant has authorised me to agree on the terms and conditions under the Declaration & Authorisation by Policy Owner/Claimant heading, on policy owner/claimant's behalf; and
- (d) I have explained to the policy owner that (i) only true copy of medical invoice(s) issued by the medical institution may be submitted to Manulife; (ii) the incurred medical invoice(s) can be reimbursed one time only regardless of the number of medical insurance policies policy owner may have; (iii) policy owner cannot claim from his/her employer, any other insurer or party for the same medical invoice(s) on the portion that will be reimbursed by Manulife. Otherwise, it may amount to fraud; (iv) policy owner will need to keep original or certified true copy of medical invoice(s) for a period of 6 months from the date of submission, and provide the same to Manulife upon request; and (v) Manulife may recover any excess amount paid to policy owner.

**Name & Code** .....  
**Branch** .....  
**Date** ..... (DD-MMM-YYYY)

**Manulife**

**The fastest way to receive payment from us!**

Credited directly into your registered bank account via PayNow.

Register PayNow with your NRIC or FIN.

**PAY NOW**

<h2>Register for PayNow</h2>	<ul style="list-style-type: none"> <li>You need to have a bank account with one of the participating banks<sup>1</sup></li> <li>To register for PayNow, use participating bank's internet banking platform, mobile banking app, or SMS<sup>2</sup></li> <li>Link your <b>Singapore NRIC</b> or <b>FIN</b> to your bank account<sup>3</sup></li> </ul>
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Register via Internet banking or mobile banking app	Register via SMS
<p><b>Step 1.</b> Log in to your bank's internet banking platform or mobile banking app.</p> <p><b>Step 2.</b> At the PayNow registration screen, link your <b>Singapore NRIC</b> or <b>FIN</b> to your bank account number. An SMS OTP verification process may be required.</p>	<p>Simply send an SMS to your bank in the required formats. Please check with your bank for details.</p>

<sup>1</sup> The list of participating banks can be found from <https://www.abs.org.sg/consumer-banking/pay-now>

<sup>2</sup> Applicable to some banks only

<sup>3</sup> For existing PayNow users who have earlier linked your mobile number to your bank account, you need not delink your mobile number. You just need to follow the steps to also link your Singapore NRIC or FIN to your preferred bank account.