CRITICAL ILLNESS CLAIM FORM
Heart Attack

中国人寿保险(新加坡)有限公司
China Life Insurance (Singapore) Pte. Ltd.

Dear Claimant

We are sorry to learn of the Life Insured's illness.

In order for us to process the claim, please provide the following:

1. Claimant's Statement (Section A of the Critical Illness Claim Form)
2. Medical Specialist Report (Section B of the Critical Illness Claim Form)
3. Copies of all diagnostic reports (e:g Histopathology report, MRI report, Troponin test results) detailed Inpatient Discharge Summary and any relevant hospital reports that are available
4. Copy of Life Insured's NRIC or Passport
5. Copy of the NRIC/FIN or Passport of the Policy Owner, if different from Life Assured

Important Notes

1. Please note that, under the policy terms and condition, the policy may be void if any information provided in this claim form are made knowingly by you that it is materially false or misleading.
2. The acceptance of this form is not an admission of liability by China Life Insurance (Singapore) Pte. Ltd. ("CLIS", "our", "us", "we").
3. All documents submitted must be in English. Any document which is in foreign language must be translated to English by a certified translator.
4. Any expense that is incurred in obtaining any of the documents required, including but not limited to the Specialist Report or medical evidences, for claim filing shall be borne by you.
5. Please submit all required documents and we will assess the claim upon receipt of all the required documents and advise whether medical reports or further documentary evidences are required.
6. The Company may communicate with you with regard to this claim by email and/or letter by post.

Submission of Documents

You may submit the claim documents personally at our Customer Care Centre, through your financial adviser representative or by post to:

Claims Department
China Life Insurance (Singapore) Pte. Ltd.
1 Raffles Place #46-00 One Raffles Place Tower 1
Singapore 048616

If you have any queries, please call us at Customer Care Hotline at (65) 6727 4800 or email us at Customercare@chinalife.com.sg .

SECTION A – CLAIMANT'S STATEMENT

(to the completed by the Life Insured who is at least 18 years old or Policy Owner if the Life Insured is below 18 years old)

1) POLICY NUMBER(S)

2) INFORMATION OF LIFE INSURED

Full Name (as shown in NRIC/ Passport)	
NRIC / FIN / Passport Number	
Date of Birth (dd/mm/yyyy)	
Gender	☐ Female ☐ Male
Marital Status	
Mailing Address	
Contact Number	
Email Address	
Occupation	
Name and Address of Employer	

3) DETAILS OF ILLNESS/ MEDICAL CONDITION

1. Describe fully the signs or symptoms for which Life Insured has consulted doctor or received treatment.	
2. Date when signs or symptoms first started (dd/mm/yyyy)	
3. Date when Life Insured first consulted a doctor for the above signs or symptoms (dd/mm/yyyy)	
4. Has Life Insured previously suffered from or received treatment for a similar or related illness/ injury?	
If yes, please provide details:	

5. Please provide the details of all doctors or specialists whom Life Insured has consulted in connection with his/ her illness/ injury:

Name of Doctor	Name and Address of Clinic/ Hospital	Date of Consultation (dd/mm/yyyy)	Reason(s) for Consultation

6. Please provide the name and address of Life Insured's regular doctor and company doctor for **ALL** other medical conditions(s):

Name of Doctor	Name and Address of Clinic/ Hospital	Date of Consultation (dd/mm/yyyy)	Reason(s) for Consultation

4) OTHER INSURANCE

1. Does Life Insured have similar benefits with other insurers?	☐ Yes ☐ No
If yes, please provide details below:	

Name of Insurer	Type of Plan	Date of Issue (dd/mm/yyyy)	Sum Insured

5) SETTLEMENT OPTION FOR APPROVED CLAIM

Please select your preferred mode of receiving the approved claim proceeds by ticking ☑ one of the boxes below:

☐ Issue a crossed cheque in my name and to be sent to my mailing address

☐ Issue a crossed cheque in my name and to be collected by my Representative

Name of Representative **Contact Number**

6) AUTHORISATION AND DECLARATION

1. I understand and agree that the submission of this form does not mean that my request will be processed. I understand that any payout under the policy shall be strictly in accordance with the policy terms and conditions.

2. I hereby declare that the information that is disclosed on this form is to the best of my knowledge and belief, true, complete and accurate, and that no material information has been withheld or is any relevant circumstances omitted. I further acknowledge and accept that China Life Insurance (Singapore) Pte. Ltd. ("CLIS") shall be at liberty to deny liability or recover amounts paid, whether wholly or partially, if any of the information disclosed on this form is incomplete, untrue or incorrect in any respect or if the Policy does not provide cover on which such claim is made.

3. I hereby warrant and represent that I have been properly authorised by the policyowner and the applicable insured(s) to submit information pertaining to such insured's claims.

4. I acknowledge and accept that the furnishing of this form, or any other forms supplemental thereto, by CLIS, is neither an admission that there was any insurance in force on the life in question, nor an admission of liability nor a waiver of any of its rights and defenses.

5. I acknowledge and accept that CLIS expressly reserves its rights to require or obtain further information and documentation as it deems necessary.

6. I confirm that I have paid in full all the bill(s)/invoice(s)/receipt(s) that I have submitted to CLIS for reimbursement and have not claimed and do not intend to claim from other company(ies)/person(s).

7. I agree to produce all original bill(s)/invoice(s)/receipt(s) that were submitted for reimbursement to CLIS for verification as it deems necessary.

8. I expressly authorise and consent to CLIS and its officers, employees and representatives collecting from, using and disclosing to any of the following persons, whether in Singapore or elsewhere, at their sole discretion, any and all information relating to the policyowner and the insured(s), including personal particulars, transactions and dealings with CLIS,:

   a) any doctor, hospital, clinic, insurance company;

   b) CLIS's holding companies, branches, representative offices, subsidiaries, related corporations or affiliates;

   c) any of CLIS's contractors or third party service providers or distribution partners or professional advisers or representatives; and

   d) any regulatory, supervisory or other authority, court of law, tribunal or person, in any jurisdiction, where such disclosure is required by law, regulation, judgement or order of court or order of any tribunal or as a matter of practice,

   for the purpose of processing, investigating and assessing this claim.

   I understand that CLIS has a Personal Data Protection Policy, which sets out the purposes for which personal data may also be used and disclosed, and it is available at www.chinalife.com.sg, which I confirm I have read and understood.

9. I agree to indemnify CLIS for all losses and damages that CLIS may suffer in the event that I am in breach of any representation and warranty provided to me herein.

I agree that this (i) CLIS shall have full access to the information stated in this form, and (ii) this authorisation and declaration shall form part of my proposed application for the relevant insurance benefits, and a photocopy of this form shall be treated as valid and binding as if it were the original.

_____

Name and Signature of Policy Owner/ Life Insured
(Policyholder to sign if Life Insured is a minor)

_____

NRIC/ FIN/ Passport Number of Policyholder/
Life Insured

_____

Date (dd/mm/yyyy)

SECTION B – SPECIALIST REPORT

1) Angioplasty and Other Invasive Treatment for Coronary Artery
2) Coronary Artery By-pass Surgery
3) Heart Attack of Specified Severity
4) Other Serious Coronary Artery Disease

(To be completed by the Life Assured's attending medical specialist)

Important Notes:

In order for us to process the claim, please submit all relevant clinical, radiological, histological, operation (if surgery has been performed), laboratory reports and other reports as follows:

1) ECG readings
2) Coronary Angiogram
3) Laboratory results evident of diagnostic elevation of cardiac enzymes CKMB, Troponin T or I
4) Operation report (if surgery has been performed)

1) INFORMATION ON SPECIALIST

Name of Specialist	
Field of Speciality	
Name of Medical Institution	

2) INFORMATION ON PATIENT

Name of Patient (as shown in NRIC/ Passport)	
NRIC / FIN / Passport Number	

3) MEDICAL RECORDS OF THE PATIENT

PART I	
1. Date when patient first consulted you for the condition? (dd/mm/yyyy)	
2. When was the last consultation? (dd/mm/yyyy)	
3. What were the presenting symptoms when you first saw the patient?	
4. When did the above symptoms first present? (dd/mm/yyyy)	

Signature of the Specialist who complete Section B	Date

5. Please provide the exact diagnosis.		
6. What is/ are the underlying cause(s)?		
7. Date of diagnosis. (dd/mm/yyyy)		
8. Date when patient/ patient's next of kin first informed of the diagnosis. (dd/mm/yyyy)		
9. Please provide dates and details of the investigation for the diagnosis. Please **attach copies** of all relevant objective test reports, which confirmed the diagnosis.		
10. Were you the doctor who first diagnosed the patient with this condition?	☐ Yes ☐ No	
11. If Yes to Question 10, over what period do your records extend? (dd/mm/yyyy)	From	To
12. If you are not the first doctor who diagnosed that patient with this condition, please provide:		
a. Name and address of the doctor who first made the diagnosis or had treated the patient for this condition.		
b. Date the diagnosis was made by the previous doctor. (dd/mm/yyyy)		
c. When was the referral made for the patient to see you? (dd/mm/yyyy)		
d. What was the reason for referral to see you? Please attach a copy of the referral letter.		
e. Please provide name and address of referral doctor.		

Signature of the Specialist who complete Section B	Date

PART II	
1. Please provide details of the initial episode below:	
a. Date of initial episode (dd/mm/yyyy)	
b. Nature of episode	
c. Duration of acute symptoms	
d. Date of return to normal activities (dd/mm/yyyy)	

2. Was there evidence of death of heart muscle due to obstruction of blood flow (Acute Myocardial Infarction)?	☐ Yes ☐ No
3. Was there history of typical chest pain?	☐ Yes ☐ No
4. Was there any sign of ECG changes evident of new death of heart muscle due to obstruction of blood flow (Acute Ischemic Heart Disease)?	☐ Yes ☐ No
5. Were there new ECG changes with development of ST elevation or depression?	☐ Yes ☐ No
6. Were there new ECG changes with development of T wave inversion?	☐ Yes ☐ No
7. Were there new ECG changes with development of pathological Q waves?	☐ Yes ☐ No
8. Were there new ECG changes with development of left bundle branch block?	☐ Yes ☐ No
If Yes to the above Question 2 to 8, please elaborate:	
Date of ECG result that you have based on to derive the diagnosis of Acute Myocardial Infarction or Acute Ischemic Heart Disease. (dd/mm/yyyy)	
Please describe the ECG changes indicative of new death of heart muscle due to obstruction of blood flow (Acute Myocardial Infarction or Acute Ischemic Heart Disease).	

Signature of the Specialist who complete Section B	Date

9. Was there elevation of cardiac enzyme Troponin (T or I) evident of death of heart muscle due to obstruction of blood flow (Acute Myocardial Infarction)? Please tick.	☐ Yes (proceed to Question 10) ☐ No (proceed to Question 11)
10. If Yes to Question 9, please state the series of elevated cardiac enzyme Troponin (T or I) and its respective date of blood test result you have based on.	
11. If No to Question 9, please provide the justification based on to confirm the diagnosis of heart muscle death due to obstruction of blood flow without elevation in cardiac enzyme Troponin (T or I).	
12. Was the rise in cardiac Troponin (T or I) measured at 0.5ng/ml and above?	☐ Yes ☐ No
13. Was the elevation of cardiac enzyme Troponin (T or I) following an intra-arterial cardiac procedure?	☐ Yes ☐ No
If Yes to Question 13, please state the name and date of intra-arterial cardiac procedure patient has received.	
14. Was there elevation of cardiac enzyme CK-MB evident of death of heart muscle due to obstruction of blood flow (acute Myocardial Infarction)?	☐ Yes (proceed to Question 15) ☐ No (proceed to Question 16)
15. If Yes to Question 14, please state the date and findings of blood test result that you have based on.	
16. If No to Question 14, please provide the justification you have based on to confirm the diagnosis of heart muscle death due to obstruction of blood flow without elevation in cardiac enzyme CK-MB.	

Signature of the Specialist who complete Section B	

17. Was the elevation of cardiac enzyme CK-MB following an intra-arterial cardiac procedure?	☐ Yes ☐ No
If Yes to Question 17, please state the name and date of intra-arterial cardiac procedure patient has received.	
18. Was there diagnostic elevation of any other cardiac enzymes?	☐ Yes ☐ No
If Yes to Question 18, please elaborate.	

Type of cardiac enzymes test	Date of test (dd/mm/yyyy)	Description of the result

19. Was there left ventricular ejection fraction less than 50%?	☐ Yes ☐ No
If Yes to Question 19, please state date of test, the results, and attach a copy of the diagnostic report.	
20. Was there imaging evidence of new loss of viable myocardium?	☐ Yes ☐ No
21. Was there imaging evidence of new regional wall motion abnormality?	☐ Yes ☐ No
If Yes to Question 20 & 21, please provide evidence of the imaging reports	
22. Please indicate which major coronary arteries were occluded and its percentage of stenosis:	

Major Coronary Artery	Percentage of Stenosis
Left main stem	
Left anterior descending	
Left circumflex	
Right coronary artery	

Signature of the Specialist who complete Section B	Date

23. Is any form of coronary artery surgery required to treat patient's coronary artery disease?			☐ Yes ☐ No
Type of Surgery	**Has patient undergone this surgery?**	**Date patient was recommended for this surgery (dd/mm/yyyy)**	**Date surgery have been performed (dd/mm/yyyy)**
Angioplasty	☐ Yes ☐ No		
Other Invasive Treatment for Coronary Artery (please specify):	☐ Yes ☐ No		
Port access procedure to correct narrowing or blockage of coronary artery(ies)	☐ Yes ☐ No		
Open-chest Coronary Artery By-pass Surgery	☐ Yes ☐ No		
Minimally Invasive Direct Coronary Artery Bypass Surgery	☐ Yes ☐ No		

24. If none of the cardiac procedure listed in Question 23 is applicable, please provide the following details:

Name and Type of Surgery	**Date patient was recommended for this surgery (dd/mm/yyyy)**	**Date cardiac surgery was performed (dd/mm/yyyy)**

Signature of the Specialist who complete Section B	Date

PART III

1. Please tick ☑ your reply to Question (a) to (e) below, if patient's condition or surgery performed in any way related to or due to:

a. AIDS, AIDS-related complex or infection by HIV?	☐ Yes ☐ No
b. Deliberate misuse of drugs or alcohol?	☐ Yes ☐ No
c. Alcohol abuse or misuse?	☐ Yes ☐ No
d. Congenital anomaly or defect?	☐ Yes ☐ No
e. Deliberate acts such as self-inflicted injuries, self-inflicted illnesses, acts violating the law or attempted suicide?	☐ Yes ☐ No

If Yes to any of Question 1 above, please provide the following details and also attach a copy of the test result.

Exact diagnosis	Date of diagnosis (dd/mm/yyyy)	Name and practice address of treating doctor

Signature of the Specialist who complete Section B	Date

2. Has the patient previously suffered from raised cholesterol, hypertension, heart attack, heart murmur, mitral valve prolapse or other heart valve disorders, chest discomfort or pain, disease of or any other disorders of the heart or blood vessels?	☐ Yes ☐ No

If Yes to Question 2, please provide the following details:

Diagnosis	Date of diagnosis (dd/mm/yyyy)	Date when patient was informed of diagnosis (dd/mm/yyyy)	Name and date (dd/mm/yyyy) of treatments	Name and Practice address of treating doctor

3. If there anything in patient's medical history which would have increased the risk of having heart disease?	☐ Yes ☐ No

If Yes to Question 3, please state the details:

4. Does the patient have or ever had any other significant health acondition?	☐ Yes ☐ No

If Yes to Question 4, please provide the following details:

Diagnosis	Date of diagnosis (dd/mm/yyyy)	Date when patient was informed of diagnosis (dd/mm/yyyy)	Name and date (dd/mm/yyyy) of treatments	Name and Practice address of treating doctor

Name and Signature of the Specialist who filled up Section B	Date
Practice Stamp of the Specialist	

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