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

ACCIDENT & HOSPITALIZATION CLAIM FORM

Name of Policy Owner/ Trustee/ Assignee

Name of Life Insured

Identification No./ Passport of Life Insured

Policy Number

FINANCIAL ADVISER REPRESENTATIVE INFORMATION

Name of Financial Adviser Representative

Representative Code

Mobile Number

IMPORTANT NOTES

Documents Required:
In order for us to process your claim, please provide the following documents:

a) Accident & Hospitalization Claim Form
b) Medical Report
c) Police Report, if applicable
d) Medical Certificate, if applicable
e) 'Part II - Attending Physician's Statement' (to be duly completed by your attending physician)

1) The acceptance of this form is not an admission of liability by China Life Insurance (Singapore) Pte. Ltd. ("CLIS", "our", "us", "we").
2) Please complete this form in BLOCK LETTERS.
3) If the Life Insured is age 18 or older, both the Life Insured and Policy Owner must personally complete and sign this form. If the Life Insured is under age 18, the Policy Owner and the Life Insured's parent or legal guardian must complete and sign this form. In cases where the Life Insured or Policy Owner is unable to sign due to physical incapacity, an immediate family member may execute this form upon submission of documented proof of relationship and a medical certification of incapacity.
4) All amendments must be countersigned with full signature by the Life Insured/ Policy Owner/ Claimant.
5) The signature of the Life Insured/ Policy Owner / Claimant must be the same as the Company's record.
6) Part I of this form must be completed by the Life Insured/ Policy Owner/ Claimant and submitted to us within 90 days of the accident date, along with all required documents.
7) Only our Customer Service Officer, a Singapore-licensed lawyer or a Notary Public may certify documents as true copies.
8) All expenses incurred in obtaining required documents, including but not limited to medical reports or medical evidence for claim filing, will be borne by you.
9) All submitted documents must be in English. Non-English documents must be accompanied by certified English translations from a licensed translator.
10) The Company reserves the rights to request for additional documents when deemed necessary.

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

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

Should you have any queries, please feel free to contact your insurance intermediary or Customer Service Hotline at (65) 6727 4800 or email us at CustomerCare@chinalife.com.sg.

PART I – CLAIMANT'S STATEMENT (To be completed by Life Insured/ Policy Owner/ Claimant)

A. GENERAL INFORMATION

1. Benefit(s) to claim

□ Daily Hospitalization Cash Benefit (due to Accident / Illness*)

□ Recuperation Benefit (non-surgical / post-surgical*)

□ Medical Expense Reimbursement Benefit (due to Accident / Illness*)

□ Other Accident Benefit _____

**Delete accordingly*

B. DETAILS OF ACCIDENT (Complete this part if you are submitting an Accident claim)

1. Please state the date and time of the accident	**Date of accident**	**Time of accident**
	(dd/mm/yyyy)	(am/pm*) *Delete appropriately
2. Please state the place of accident		
3. Describe in detail how the accident happened		
4. Was the Life Insured under the influence of alcohol / drugs at the time of the accident?	□ Yes (If Yes, please provide Alcohol Test Report)	□ No
5. Was there a police report filed?	□ Yes (Please provide a copy of the police report)	□ No
6. Please describe in detail the injuries sustained		

7. Please state the date of the first consultation and provide details of doctor(s)/ hospital(s) whom you have consulted with connection for these injuries.

Name of Doctor	**Name and Address of Clinic/ Hospital**	**Date of Consultation (dd/mm/yyyy)**	**Treatment**

8. Please state the reason if the Life Insured did not seek treatment immediately after the accident.

9. Was the Life Insured hospitalized due to these injuries? (Please tick)	□ Yes (If yes, please provide period of hospitalization below)	□ No
	Period of Hospitalization	
	Date of hospital admission	Date of hospital discharge
	(dd/mm/yyyy)	(dd/mm/yyyy)

10. Date of medical leave	From: (Date: dd/mm/yyyy)	To: (Date: dd/mm/yyyy)
11. Is there any relationship between the Registered Medical Practitioner/ Medical Services Provider and the Life Insured/ Policy Owner/ Claimant? If Yes, please provide details of the relationship.	□ Yes (If Yes, please state the relationship)	□ No
	Relationship	

C. DETAILS OF ILLNESS (Complete this part if you are submitting an Illness claim)

1. Please describe the symptom(s) experienced		
2. Please state the date symptoms first occurred		(dd/mm/yyyy)
3. Please state the Doctor's Diagnosis		
4. Please state the date of diagnosis was first made		(dd/mm/yyyy)
5. Please state the date of hospitalization	**Period of Hospitalization**	
	Date of hospital admission	Date of hospital discharge
	(dd/mm/yyyy)	(dd/mm/yyyy)

6. Please state the date of the first consultation and provide details of doctor(s)/ hospital(s) whom you have consulted with connection for the illness.

Name of Doctor	Name and Address of Clinic/ Hospital	Date of Consultation (dd/mm/yyyy)	Diagnosis

7. Has the illness being treated previously? If yes, please state the name of doctor, address of the attending doctor and consultation dates for previous treatment received.	□ Yes (If Yes, please provide the details below)	□ No

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

8. Was there any surgery performed on this illness?	□ Yes (If Yes, please provide the details below)	□ No

Name of Doctor	Name and Address of Hospital	Type of Surgical Operation or Procedure	Date of Operation or Procedure

9. **For Females only:**

9a. Was the Insured pregnant at the time of hospitalization.	□ Yes (If Yes, please provide the details)	□ No

Name of Obstetrician/ Gynaecologist	Name and Address of Clinic/ Hospital	Date of Consultation (dd/mm/yyyy)	Diagnosis

9b. Was the Insured's hospitalization relate to her pregnancy?		□ Yes (If Yes, please provide the details below)	□ No
Name of Obstetrician/ Gynaecologist	**Name and Address of Clinic/ Hospital**	**Date of Consultation (dd/mm/yyyy)**	**Diagnosis**

10. Is there any relationship between the Registered Medical Practitioner/ Medical Services Provider and the Life Insured/ Policy Owner/ Claimant? If Yes, please provide details of the relationship.	□ Yes (If Yes, please state the relationship)	□ No
	Relationship	

D. DETAILS OF EMPLOYMENT

1. Please provide the Name and Address of employer.

2. Please state your occupation and describe the duties in details.

E. OTHER INSURANCE

1. Did the Life Insured submit a claim with other Insurance Company/ Third Party for the same incident? Please tick		□ Yes (If Yes, please provide the details below)	□ No
Name of Insurance Company/ Employer/ Third Party	**Nature of Claim**	**Amount Claimed**	**Policy Number (if available)**

F. SETTLEMENT OPTION (Please indicate the option you wish to receive your payment)

□ PayNow NRIC/FIN No : _____ (Your Singapore NRIC/FIN number must be linked to a PayNow account)

To register for PayNow
Log in to your bank's internet or mobile banking account > Sign up for PayNow > Link your PayNow to your NRIC/FIN No.

□ Direct credit into my bank

Name of Bank : _____

Account Number:_____

Please fill in your bank details and **submit a copy of the policyowner's bank book or bank statement, stating the account holder's name and account number**. We accept bank statements with the bank balances and transactions being blacked out, and truncated e-statements downloaded from the banks' mobile application, provided that the document shows the account holder's name and account number on the same page.

Important note
To avoid delay in payment,
(1) please ensure that you have signed up for PayNow with your bank by linking it to your NRIC/FIN No.
(2) please ensure that your bank details are accurate and matches your bank records. We do not allow 3rd party payment.

G. 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.

H. SIGNATURE & PERSONAL DETAILS

	Policy Owner	Life Insured (if Life Insured is above age 18 years)
Signature & Date (dd/mm/yyyy)		
Name		
Identification No./ Passport No.		
Mailing Address		
Contact details (Mobile & Email Address)		

PART II – ATTENDING PHYSICIAN'S STATEMENT (To be completed by the Attending Physician at Claimant's expense)			
A. PARTICULARS OF PATIENT			
Name of Patient		**NRIC/ Passport No.**	
Patient's occupation, nature of work. Name of Employer and Company Address.			
B. PARTICULARS OF ATTENDING PHYSICIAN			
Name of Doctor			
Field of Specialty			
Name of Medical Institution			

C. DETAILS OF ACCIDENT (Complete Part C & E if the claim is due to an Accident)			
1. Please state the date of accident	**Date of accident**		**Time of accident**
	(dd/mm/yyyy)		(am/pm*) *Delete appropriately
2. Please describe in detail how the accident occurred			
3. Please provide details, nature and extent of injury sustained			
4. What is your diagnosis?			
5. Was the injury sustained consistent with the accident described above?	□ Yes		□ No If No, please elaborate below.
6. Was the injury caused solely by accident described above?	□ Yes		□ No If No, please elaborate below.
7. Please advise how the patient was admitted	□ Emergency admission	□ Doctor referral	□ Others, please specify:
7a. If admission is via a doctor referral, please provide name and address of the referring doctor	**Name of Doctor**		**Name and Address of Clinic/ Hospital**
7b. Please state the clinical basis for the referral and enclose a copy of the referral letter			

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China Life Insurance (Singapore) Pte. Ltd.
1 Raffles Place #46-00 One Raffles Place Tower 1 Singapore 048616 Tel: 6727 4820 Website: www.chinalife.com.sg
Company Registration Number: 201433645N

8. Were there any underlying illnesses/ conditions, which would likely have contributed to the accident/ injury?	□ Yes (If Yes, please provide details below)		□ No
	Diagnosis	**Date of Diagnosis (dd/mm/yyyy)**	**Name & address of doctor(s) who made the diagnosis**
8a. Was the patient informed of the above diagnosis?	□ Yes		□ No
8b. If Yes, when was the patient informed of the diagnosis?	(dd/mm/yyyy)		
8c. How has the illness contributed to the accident/ injuries?			
D. DETAILS OF ILLNESS (Complete Part D & E if the claim is due to an Illness)			
1. When did the patient first consult you for the condition?	(dd/mm/yyyy)		
2. What was/were the sign(s) and symptom(s) presented during the first consultation?			
3. When did the patient first notice the sign(s) and symptom(s) of the condition diagnosed?	(dd/mm/yyyy)		
4. In your opinion, how long has/have the sign(s) and symptom(s) lasted prior to the first consultation with you?			
5. Please state the exact diagnosis and the date of diagnosis of the condition	**Diagnosis**		**Date of Diagnosis (dd/mm/ yyyy)**
6. Was the patient informed of the diagnosis? If yes, when was the patient informed?	□ Yes (If Yes, please provide details below)		□ No
	If yes, please provide the date. (dd/mm/yyyy)		
7. What is the underlying cause of the condition diagnosed?			
8. Has the patient consulted any other doctors/ hospitals for any sign(s) and symptom(s)/ condition prior to the first consultation with you?	□ Yes (If Yes, please provide details below)		□ No
	Name of Doctor(s)	**Name & Address of the Clinic(s)/ Hospital(s)**	**Date of Consultation (dd/mm/yyyy)**

9. Are there other illness(es) that would have contributed to the patient's conditions?	□ Yes (If Yes, please provide details below)		□ No
	Diagnosis	**Date of Diagnosis (dd/mm/yyyy)**	**Name & Address of Doctor(s) who made the Diagnosis**

E. DETAILS OF CONSULTATIONS

1. Was the patient admitted to a hospital? Please tick	□ Yes (If Yes, please provide details below)	□ No
2. Name of hospital patient was admitted to		
3. Date and time of admission	**Date of admission**	**Time of admission**
	(dd/mm/yyyy)	(am/pm*) *Delete accordingly
4. Date and time of discharge	**Date of discharge**	**Time of discharge**
	(dd/mm/yyyy)	(am/pm*) *Delete accordingly
5. Was there treatment/ surgery performed on the patient?	□ Yes (If Yes, please provide details below)	□ No

Type of Treatment/ Surgery	**Surgical Code**	**Name of Doctor(s)**	**Date of Treatment/ Surgery**

6. Was the patient seen/treated by any other doctor(s) for the same injuries/ illness?	□ Yes (If Yes, please provide details below)	□ No
a. Please provide the details of the doctor(s) whom the patient has consulted treatment for these injuries/ illnesses.	**Name and Address of Doctor(s)**	**Date of Consultation (dd/mm/yyyy)**
b. If Yes, please state the date of first consultation.	(dd/mm/yyyy)	
c. Please indicate approximate date from which the patient first noticed symptoms of condition.	(dd/mm/yyyy)	
d. In your view, if the condition existed before symptoms became apparent to the patient, please indicate when this condition began to develop.	(dd/mm/yyyy)	
e. Was the patient informed of the diagnosis?	□ Yes (If Yes, please provide details below)	□ No
f. Please state the date that the patient was informed of the diagnosis.	(dd/mm/yyyy)	

7. Is the patient's condition associated with the following?		
(a) Ionizing, radiation or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel or from nuclear weapons material.	□ Yes	□ No
(b) The influence of alcohol?	□ Yes (If Yes, please provide details below)	□ No
	If Yes, please state the blood alcohol content and quantity consumed.	
(c) The influence of drugs?	□ Yes (If Yes, please provide details below)	□ No
	If Yes, please state the drug type and quantity consumed.	
(d) Self-inflicted injury – e.g. suicide, attempted suicide.	□ Yes	□ No
(e) engaging in any dangerous activities or sports including caving, potholing, rock climbing or mountaineering which involves using ropes, any underwater activities involving underwater breathing apparatus, sky diving, cliff diving, bungee jumping, BASE jumping, paragliding, hand-gliding, parachuting, white-water rafting, wakeboarding, water-skiing, dragon boating, motor-rally or racing of any kind other than on foot, handling of explosives or firearms, hunting, horse riding, polo, show jumping and mountain biking, etc.	□ Yes	□ No
(f) engaging in any sport in a professional capacity.	□ Yes	□ No
(g) Treatment of alcoholism or drug abuse.	□ Yes	□ No
(h) Treatment of psychiatric, emotional, personality, mental and nervous disorders including depression.	□ Yes	□ No
(i) Any forms of dental treatment?	□ Yes	□ No
(j) Provoked homicide or assault or any act or event arising, directly or indirectly, in connection with the collaboration or provocation of the Life Insured.	□ Yes	□ No
(k) Any elective cosmetic or plastic surgery not necessitated by injury or illness.	□ Yes	□ No
(l) Treatment related to birth defects birth defects, including hereditary conditions, and congenital illness or abnormalities.	□ Yes	□ No
(m) Elective abortion, spontaneous miscarriage that occurred within first trimester of pregnancy, birth control*, sterilization*, sub-fertility* or impotence treatment. **for male or female*	□ Yes	□ No
(n) Pregnancy and childbirth (including Caesarean section, vacuum extraction or forceps delivery and consequences and complications arising thereof).	□ Yes	□ No
(o) Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex or infection by Human Immunodeficiency Virus (HIV) except HIV due to Blood Transfusion and Occupationally Acquired HIV.	□ Yes	□ No
(p) Sexually transmitted diseases.	□ Yes	□ No
(q) Any treatment for obesity, weight reduction or weight improvement regardless of whether it is medically necessary or otherwise.	□ Yes	□ No

ATTENDING PHYSICIAL'S NAME AND SIGNATURE	
Name and Signature of the Attending Physician who completed this form	**Date**
Practice Stamp of the Attending Physician	