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

CRITICAL ILLNESS CLAIM FORM
Cancer

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 required documents:

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

Important Notes

1. Please note that under the policy terms and conditions, the policy may be void if you knowingly provide materially false or misleading information in this claim form.
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. All expenses incurred in obtaining required documents, including but not limited to specialist reports or medical evidence for claim filing, will be borne by you.
5. Please submit all required documents. We will assess your claim upon receipt of the complete documentation and advise whether additional medical reports are required.
6. The Company reserves the rights to request for additional documents when deemed necessary.
7. The Company may communicate with you regarding this claim via email and/or postal mail.

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 our 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?	□Yes □No

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

□ PayNow NRIC 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.

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 | Date (dd/mm/yyyy)

SECTION B – SPECIALIST REPORT

1) Cancer

(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 with this Specialist Report:

1) Histopathological / Biopsy reports
2) Operation reports (if surgery has been performed)

1) INFORMATION ON SPECIALIST

Name of Specialist	
Field of Specialty	
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)	
5. Please provide the exact diagnosis.	

Signature of the Specialist who complete Section B	Date

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

13. Please indicate the primary and exact anatomical site of the tumour.	
14. Is the tumour malignant?	□ Yes □ No
a. If Yes to Question 14, please confirm if there is histological evidence of uncontrolled growth of malignant cells with invasion and destruction of normal tissue? (Please attach the histology report with this Specialist Report)	□ Yes □ No
b. If histological evidence is not available, please advise us the medical justification to establish the diagnosis of malignant tumour.	
15. What is the staging of the tumor based on TNM Classification? If the tumor has no TNM Classification, please advise us the type of staging / grading system (e.g. RAI staging, Clark Level, FIGO system, etc.) used to stage the tumor and its equivalent classification in TNM staging system:	
a. Was the disease completely localized?	□ Yes □ No
b. Was there invasion of adjacent tissues?	□ Yes □ No
c. Were regional lymph nodes involved?	□ Yes □ No
d. Were there distant metastases?	□ Yes □ No
If Yes to Question 15(d), please provide full details, including site of metastases:	
16. Was the diagnosis of cancer derived based on the finding of tumour cells and/ or tumour-associated molecules in blood, saliva, faeces, urine or any other bodily fluid in the absence of further verifiable evidence?	□ Yes □ No

Signature of the Specialist who complete Section B	Date

17. Please tick ✓ the box below if the tumour was histologically classified as any of the following?	
a. Was the diagnosis of tumour Benign?	□ Yes □ No
b. Was the diagnosis of tumour Pre-malignant?	□ Yes □ No
c. Was the diagnosis of tumour Carcinoma-in-situ?	□ Yes □ No
d. Was the diagnosis of tumour classified as Cervical Dysplasia CIN-1, CIN-2 and CIN-3?	□ Yes □ No
If Yes to Question 17(d), please state the exact Cervical Intraepithelial Neoplasia (CIN) category and if there is pathologic evidence of carcinoma in situ:	
e. Was the diagnosis of tumour having borderline malignancy?	□ Yes □ No
f. Was the diagnosis of tumour having any degree of malignant potential?	□ Yes □ No
g. Was the diagnosis of tumour having suspicious malignancy?	□ Yes □ No
h. Was the diagnosis of tumour classified as neoplasm of uncertain or unknown behaviour?	□ Yes □ No
18. Please tick ✓ the box to Question (a) to (f) below, if the patient's condition is skin cancer, please confirm its type based on the following:	
a. Is the patient's condition malignant melanoma that has not invaded beyond the epidermis?	□ Yes □ No
b. Is the patient's condition hyperkeratosis skin cancer?	□ Yes □ No
c. Is the patient's condition basal cell skin cancer?	□ Yes □ No
d. Is the patient's condition squamous cell skin cancer?	□ Yes □ No
e. Is the patient's condition skin confined primary cutaneous lymphoma or dermatofibrosarcoma protuberans?	□ Yes □ No
f. Is the patient's condition invasive melanoma of less than 1.5mm Breslow thickness, or less than Clark Level 3?	□ Yes □ No
If Yes to Question 18(f), please provide details of size, thickness and depth of invasion. Please also state if there is any pathologic evidence of invasion beyond the epidermis or metastases to lymph nodes.	

Signature of the Specialist who complete Section B	Date

19. Is the patient's condition prostate cancers histologically described as T1N0M0?	□ Yes □ No
If Yes to Question 19, please tick the exact stage T1 classification.	□ **T1a** □ **T1b** □ **T1c**
20. Is the patient's condition thyroid cancer histologically described as T1N0M0?	□ Yes □ No
If Yes to Question 20, please state the size in diameter:	
21. Is the patient's condition urinary bladder cancer histologically described as T1N0M0?	□ Yes □ No
22. Is the patient's condition papillary micro-carcinoma of the bladder?	□ Yes □ No
If Yes to Question 22, please explain the medical justification to establish the diagnosis of papillary micro-carcinoma of the bladder:	
23. Is the patient's condition of 'Gastro-Intestinal Stromal tumours (GIST) with mitotic count' of less than or equal to 5/50 HPFs or histologically classified as Stage 1 or 1A accordingly to the latest edition of the AJCC Cancer Staging Manual?	□ Yes □ No
If No to Question 23, please state the tumour TNM classification and its mitotic count in HPFs:	
24. Is the patient's condition Chronic Lymphocytic Leukaemia less than RAI Stage 3?	□ Yes □ No
If No to Question 24, please state the type of leukaemia and its RAI staging	
25. Is the tumour a neuroendocrine tumour histologically classified as T1N0M0 (TMN classification) or below?	□ Yes □ No
If No to Question 25, please state the type of tumour and its staging.	

Signature of the Specialist who complete Section B	Date

26. Is the patient's condition a bone marrow malignancy which does not require recurrent blood transfusions, chemotherapy, targeted cancer therapies, bone marrow transplant, hematopoietic stem cell transplant or other major interventionist treatment?	□ Yes □ No
27. Is the tumour in the presence of HIV infection?	□ Yes □ No
If Yes to Question 27, please indicate patient's status of patient's HIV infection and date when he/she was diagnosed with HIV infection:	
28. Please provide details of all investigations / test performed. Please enclose copies of all reports including biopsy, reports, cytology reports, X-rays, CT scans, other imaging studies, laboratory evidence, surgical reports, etc. and any relevant hospital reports that are available.	

PART II

29. Did the patient undergo any surgery? If Yes, please provide the following details and a copy of the operation report.	□ Yes □ No

Date of surgery (dd/mm/yyyy)	Name of surgery	Was surgery performed for total or partial organ removal?	Reason for performing the surgery

30. Did the patient undergo any other type of non-surgical treatment option? (e.g. chemotherapy, radiotherapy, etc.) If Yes, please provide the following details.	□ Yes □ No

Date of treatment (dd/mm/yyyy)	Type of treatment	Patient's response to treatment

Signature of the Specialist who complete Section B	Date

PART III

31. Has the patient previously suffered from cancer, tumour, cyst or growth of any kind, or enlarged nodes? If Yes, please provide the following details:	□ Yes □ No

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

32. Is there anything in patient's medical history which would have increased the risk of having cancers? If Yes, please provide the following details:	□ Yes □ No

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

33. Does the patient have or ever had any other significant medical condition? If Yes, please provide the following details:	□ Yes □ No

Diagnosis	Date of diagnosis (dd/mm/yyyy)	Date when patient was informed of diagnosis (dd/mm/yyyy)	Name and date 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	