中国人寿 CHINA LIFE | 新加坡 SINGAPORE

# CRITICAL ILLNESS CLAIM FORM
# Stroke with Permanent Neurology Deficit

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? | ☐ 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) Stroke with Permanent Neurological Deficit

**(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) CT scan
2) MRI scan report

### 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. | | |

| | |
|---|---|
| Signature of the Specialist who complete Section B | Date |

| **PART II** | |
|---|---|
| 1. Please describe the initial episode regarding the onset of the patient's stroke condition as follows: | |
| a. Date of initial episode (dd/mm/yyyy) | |
| b. Nature of episode | |
| c. Duration of acute symptoms | |
| d. Has there been an infarction of brain tissue, cerebral and subarachnoid haemorrhage, intracerebral embolism and cerebral thrombosis? | ☐ Yes ☐ No |
| e. Has the patient returned or is the patient able to return to his/her normal duties? | ☐ Yes (please answer (i)) ☐ No (please answer (ii)) |
| i. If Yes, please state the date patient has returned or is expected to return to his/ her normal duties? (dd/mm/yyyy) | |
| ii. If No, please state the patient's current physical and mental limitations that prevent him/ her from returning to work. Please make reference to the date of your assessment. | |
| f. Are the investigation or findings consistent with the diagnosis of new Stroke? | ☐ Yes ☐ No |
| If Yes, please provide details and **attach copies** of all reports, CT scan, MRI, laboratory test results etc. | |
| **Permanent neurological deficit with persisting clinical symptoms means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the Life Insured. Symptoms that are covered include numbness, paralysis, localised weakness, dysarthria (difficult with speech), aphasia (inability to speak), dysphagia (difficulty swallowing), visual impairment, difficult in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.** | |
| g. Was there evidence of permanent neurological deficit lasting for at least 6 weeks after the date of stroke diagnosis? | ☐ Yes ☐ No |
| h. If Yes, please provide the details as follows: | |

| | |
|---|---|
| Signature of the Specialist who complete Section B | Date |

| Date of last assessment (dd/ mm/yyyy) | Please specify the exact body parts involved | Is the symptom expected to last throughout the lifetime of the patient? | | Please elaborate with supporting evidence |
|---|---|---|---|---|
| | | ☐ Yes | ☐ No | |
| | | ☐ Yes | ☐ No | |
| | | ☐ Yes | ☐ No | |
| | | ☐ Yes | ☐ No | |
| | | ☐ Yes | ☐ No | |
| | | ☐ Yes | ☐ No | |
| | | ☐ Yes | ☐ No | |

| 2. Was the diagnosis of stroke classified as any of the following? | |
|---|---|
| a. Transient ischaemic attacks? | ☐ Yes ☐ No |
| b. Brain damage due to an accident or injury? | ☐ Yes ☐ No |
| c. Brain damage due to an infection? | ☐ Yes ☐ No |
| d. Brain damage due to vasculitis? | ☐ Yes ☐ No |
| e. Brain damage due to inflammatory disease? | ☐ Yes ☐ No |
| f. Vascular disease affecting the eye? | ☐ Yes ☐ No |
| g. Vascular disease affecting the optic nerve? | ☐ Yes ☐ No |
| h. Ischaemic disorders of the vestibular system? | ☐ Yes ☐ No |
| i. Secondary haemorrhage within pre-existing cerebral lesion? | ☐ Yes ☐ No |

| 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 |
| f. Donation of any of the Life Insured's organs? | ☐ Yes ☐ No |

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

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

| | |
|---|---|
| 2. Has the patient previously suffered from stroke or any related illnesses (e.g. hypertension, transient ischaemic attack, angina or other cardiovascular diseases)? | ☐ Yes ☐ No |

If Yes, 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 of treatments (dd/mm/yyyy) | Name and Practice address of treating doctor |
|---|---|---|---|---|
| | | | | |
| | | | | |

| | |
|---|---|
| 3. Is there anything in the patient's medical history which would have increased the risk of having a stroke, intracranial aneurysm, arterio-venous malformation, hydrocephalus or narrowing of carotid artery? | ☐ Yes ☐ No |

| | |
|---|---|
| Signature of the Specialist who complete Section B | Date |

If Yes, please state the details.

| 3. Does the patient have or ever had any other significant health condition? | ☐ Yes ☐ No |
|---|---|

If Yes, 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 of treatments (dd/mm/yyyy) | Name and Practice address of treating doctor |
|---|---|---|---|---|
| | | | | |
| | | | | |

| Name and Signature of the Specialist who filled up Section B | Date |
|---|---|

Practice Stamp of the Specialist