

Notes:

- The issue of this form or any other form(s) does not represent any admission of liability by Manulife (Singapore) Pte Ltd ("Company").
- This form should be completed by the Claimant. (Life Insured or Policyowner as the case may be.)

Please tick (✓) the box where appropriate.

- Manucare
 Mediacash Benefit / Hospitalisation Benefit
 Hospital & Surgical Benefit

Policy No.
Claim No.

Part A - Claimant's Statement (To be fully completed and signed by the policyowner or claimant if insured is not medically fit to do so)
1. CLAIMANT'S PARTICULARS

Name of Claimant/Owner: _____ NRIC/Passport No: _____

Address: _____ Relationship: _____

_____ Tel No.: _____

2. INSURED'S PARTICULARS

Name of Life Insured: _____ NRIC/Passport No: _____

Date of Birth: _____ Age: _____ Sex: _____ Tel No.: _____

Address: _____

_____ Occupation: _____

3. DETAILS OF HOSPITALISATION

- (a) Full name and address of Hospital in which Life Insured was confined with respect to this claim

- (b) Name of Attending Doctor (s): _____

- (c) Date (s) and Period (s) of:

Hospitalisation (i) From _____ To _____ (ii) From _____ To _____

Intensive Care (ii) From _____ To _____ (ii) From _____ To _____

- (d) How was the Life Insured admitted to the hospital? (please tick ✓)

Referral by a General Practitioner / Specialist / Other Hospital* (please delete accordingly)
 Please provide details. _____

A & E department

4. (a) Describe in detail the symptoms for which the life insured consulted a doctor.

(b) When did the symptoms first appear? _____ / _____ / _____

dd mm yyyy

(c) Date when the Life Insured first consulted a doctor _____ / _____ / _____

dd mm yyyy

(d) Reason for confinement in the above hospital:

5. (a) Nature of Treatment / Surgery:

(b) Surgery: _____ Date: _____ / _____ / _____

dd mm yyyy

6. (a) Total Cost of Medical Procedure: _____

Please forward all relevant original medical practitioner's receipts and all official hospital bills/receipts. Photocopies of original documents will not be accepted.

(b) Is the Life Insured eligible for benefits from any other sources? Yes No

If "Yes", please provide details.

7. Please provide fully the extent and nature of the illness or injury.

8. Has similar condition occurred in the past? Yes No

If yes, please provide details including names and addresses of doctors consulted below:

(a) Details of any other doctors whom the Life Insured has consulted for the above illness / condition at any time before the Hospitalisation(s) stated above.

Name of Doctor(s)	Address(es)	Date(s) of First Consultation

(f) Doctor who treated or is treating the above life insured in the above hospital:

(i) Full Name : _____

(ii) Full Address: _____

12. OTHER INSURANCES

Are you claiming from any other insurance company or other sources (e.g. employer, other insurances including Medishield, Incomeshield, Healthshield, Workmen's Compensation Act) in respect of this hospitalisation? Yes No

If 'Yes', please provide the following information and a copy of the respective payment / benefit schedule.

Name of Employer, Insurance Company, etc	Policy Number	Date of Issue	Type of Plan	Claim Amount	Claim Notified (Yes/ No)

DECLARATION AND AUTHORISATION

I **declare** that all answers given by me in this form are, to the best of my knowledge and belief, true and complete.

I **consent** to the Company seeking / providing information about me from / to any medical source, insurance office, organisation or person, governmental organisation and / or regulatory body. **A photographic copy of this authorisation shall be as valid as the original.**

I **agree** to bear the fees (if any) payable for any reports obtained for the purpose of processing of this claim. I understand that these reports may not be made available to me and that the Company reserves the right not to release these report(s) or a copy of these report(s) to me. I **give** my consent for the fees to be deducted from the claim that is payable to me, if it is admitted.

Signature of Claimant

Signature of Witness

Name (as per NRIC):

Date:

Name (as per NRIC):

NRIC/ PP No:

Contact No:

Date:

DOCUMENTS REQUIRED FOR CLAIM SUBMISSION

The following documents are required by the Company to assess a Mediacash claim or Manucare claim:

MEDICASH CLAIM	MANUCARE CLAIM
<p>1. Hospitalisation Claim Form</p> <p>Please note that the Claim Form consists of 2 Sections:</p> <ul style="list-style-type: none"> • Part A - Claimant's Statement To be fully completed and signed by the Policyowner. • Part B - Attending Physician's Statement <ul style="list-style-type: none"> – To be fully completed and signed by the Attending Physician / Surgeon. – Required if the life insured has been admitted to the hospital for more than 5 days. <p><i>Please note that the fee for completion of the Attending Physician's Statement shall be borne by the policyowner.</i></p>	<p>1. Hospitalisation Claim Form</p> <p>Please note that the Claim Form consists of 2 Sections:</p> <ul style="list-style-type: none"> • Part A - Claimant's Statement To be fully completed and signed by the Policyowner. • Part B - Attending Physician's Statement To be fully completed and signed by the Attending Physician / Surgeon. <p><i>Please note that the fee for completion of the Attending Physician's Statement shall be borne by the policyowner.</i></p>
<p>2. Original Hospital Bills/ Medical Certificates</p> <p>Please submit the <u>original final itemised hospital bills or medical certificates</u>.</p>	<p>2. Original Hospital Bills/ Medical Certificates</p> <p>Please submit the <u>ORIGINAL FINAL itemised hospital bills and receipts</u>. If there are any medical reports/ lab investigation results/ Inpatient Discharge Summary, please submit them together with the bills/ receipts.</p>
<p>3. Clinical Abstract Application (Insurance Claim) Form</p>	<p>3. Clinical Abstract Application (Insurance Claim) Form</p>
<p>4. Submission of claim documents</p> <p>Please submit all claim documents through your representative or directly to Manulife (Singapore) Pte Ltd.</p>	<p>4. Submission of claim documents</p> <p>Please submit all claim documents through your representative or directly to Manulife (Singapore) Pte Ltd.</p>

Notes to Attending Physician:

1. Please return the fully completed Attending Physician's Statement to the Company.
2. The respective fee for this report is to be paid by the policyowner.

Policy No.
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Part B - To be completed by the attending physician/ surgeon who personally examined and treated the Life Insured upon admission to hospital

Name of Patient: _____ NRIC/Passport No: _____

I DO HEREBY CERTIFY that I personally examined the Life Insured immediately prior to / during *his/her confinement in Hospital as described below, and that my medical opinion is the following:

1. Reason for Confinement: _____
2. Nature of Sickness* or Injury*: _____
3. (a) Please state symptoms presented and date symptoms first appeared.

Symptoms presented at first consultation	Date symptoms first started (dd/mm/yyyy)

What is the source of this information?

Patient / Referring Doctor / Others*

If 'Others', please specify: _____

- (b) Diagnosis: _____

- (c) Diagnosis was first made by (name of doctor): _____

- (d) Date of Diagnosis: _____ / _____ / _____
dd mm yyyy

- (e) Date Diagnosis was made known to the patient: _____ / _____ / _____
dd mm yyyy

- (f) Was the patient under the influence of alcohol? Yes No

If yes, what was the blood alcohol content? _____

- (g) Was the Patient under the influence of any other drugs? Yes No

If yes, please provide name of drugs and results of any blood tests performed.

- (h) Is the condition self-inflicted? Yes No

If yes, please provide details.

* Please delete where appropriate

(c) Is the current treatment related to the following conditions? Yes No

If 'Yes', please tick the box (es):

- Pregnancy, childbirth, abortion, miscarriage, prenatal or postnatal care, birth control, sterilisation, infertility
- Alcoholism
- Drug addiction or abuse
- Depression, mental or nervous disorder or "rest cures"
- Birth defects, including hereditary conditions, and congenital sickness or abnormalities
- Sexually-transmitted disease, AIDS or any illness caused by or related to the Human Immuno-deficiency Virus (HIV)
- Obesity, weight reduction or weight improvement

If you have ticked any of the above boxes, please provide details.

(d) Is the patient still on follow-up treatment? Yes No

If 'Yes', please specify the type of treatment / medication.

(e) How frequent does the patient seek treatment since discharge from hospital?

(f) What is the expected length of follow up?

5. (a) Please state the periods of hospitalisation.

Name of Hospital	Period(s) of Hospitalisation		Period(s) of Intensive Care	
	From	To	From	To

- (b) Was surgery performed for this condition? Yes No

If 'Yes', please specify.

Nature of Surgical Operation (s)	Date (s) performed (dd/mm/yyyy)	Surgical Table

- (c) How would you classify this surgery?

Cosmetic Medically necessary

- (d) Is the surgery performed an elective cosmetic or plastic surgery? Yes No

If 'Yes', please provide details.

- (e) Is further surgery likely to be required? Yes No

If 'Yes', please specify tentative date of surgery: _____ / _____ / _____
dd mm yyyy

6. (a) Has the patient previously suffered from the same illness in respect of which he / she is claiming now?

Yes No

If 'Yes', please state:

(i) Date when illness was first diagnosed: _____ / _____ / _____
dd mm yyyy

(ii) Name and address of the doctor who first treated him / her.

- (b) Has the patient been admitted to any hospital before, either for the same or different cause?

Yes No

If 'Yes', please state.

Period (s) of Hospitalisation	Diagnosis	Hospital	Name(s) & Address(es) of Attending Doctor(s)

- (c) Is the patient suffering or has suffered from any other significant illnesses? Yes No
 If 'Yes', please state.

Description of Illness(es)	Date(s) of Consultations (dd/mm/yyyy)	Name(s) & Address(es) of Attending Doctor(s)

7. Please provide us any other additional information that will enable the Company to assess this claim.

8. Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the patient's claim.

Signature of Doctor

Date

Name and Qualification (printed)

Address & Official Stamp