HSBC

HOSPITAL CLAIM FORM

This Claim Form is to facilitate your Claim in the event Insured Person/s is confined to hospital while being Insured. You can help to avoid unnecessary delay in processing your claim by ensuring that:

Section A, B, C are fully completed and that you have completed and signed the Declaration and Authorisation. Section D is to be completed and signed by the Claimant's Doctor or Attending Physician. Please submit with this Claim Form, the Hospital Bill (original or copy) as evidence of hospitalization. THE CLAIMANT IS RESPONSIBLE FOR ANY EXPENSES INCURRED IN OBTAINING MEDICAL EVIDENCE IN SUPPORT OF A CLAIM.

As you will appreciate we must be able to satisfy ourselves as to the validity of all claims and to establish the exact period of and reason for hospitalization to ensure that the correct Benefit is paid.

SECTION A: Policyholder Information **Policy No:**

Policyholder's Name:	I/C No:
Address:	
Occupation:	Tel No:
Bank and/or Card Account Number (through which premiums are charged):	

SECTION B: Claimant Information

Claimant Name:		Occupation:	
Address:			
I/C No:	Tel No:	Date of Birth:	Sex: Male ☐ Female ☐

SECTION B: Claimant Information

1	Describe Injury or Sickness:	
2a	If injury – Date of Accident:	Date:
2b	If Sickness – When did you first notice Onset of this medical problem:	
3	If injury – please detail the circumstances of the Accident:	
4	Has the claimant ever seen a Doctor for this or any similar condition in the past:	Yes ☐ No ☐
5	If YES – please give dates and Name/s and Address/es of Doctors and/or Hospitals:	Date:
		Name:
		Address:
6	Period of Hospital Confinement for which claim is made:	Admission Date:
		Discharge Date:
7	Name of Hospital:	
8	Address:	
9	Country (if outside Singapore):	

HSBC Insurance (Asia) Limited
21 Collyer Quay #12-01 HSBC Building Singapore 049320
Tel: (65) 6538 0880 Fax: (65) 6538 0660

Incorporated in the Hong Kong SAR with limited liability.

10	If Claimant to whom this claim relates is or was Hospitalized outside Singapore, please give the Following additional information:		
a	Claimant's usual address:		
b	Purpose of the overseas trip:		
c	Intended itinerary or destination:		
d	Intended duration of overseas trip:	From:	To:
11	Claimant;s usual Doctor:	Name:	
		Address:	

DECLARATION AND AUTHORISATION

1. I declare that the above information is true and complete to the best of my knowledge and belief.
2. I hereby authorize any Doctor or any other person who has ever medically attended to the claimant, or any Hospital in which he or she has been treated to disclose any relevant knowledge or information which they acquired to HSBC Insurance (Asia) Limited OR their Authorised Representative. A photocopy of this authorization shall be considered as effective and valid as the original.
3. I hereby request and authorize HSBC Insurance (Asia) Limited to pay Benefit due in respect of this Claim to (If Claimant is under 18 years old):

Claimant's Signature	Policyholder's Signature
Name	Name
Date	Date

Note: If (a) The Policyholder is claiming on his own behalf or (b) the Claimant concerned is a Child under 18 years of age – only the Policyholder's Signature is required.

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HOSPITAL CLAIM FORM -Attachment

Attending Physician's Statement

1	Name of Patient:	
2a	Diagnosis of condition(s):	
2b	What were the complaints or physical findings?	
2c	Was the condition related to employment?	Yes ☐ No☐
	If YES, please give details:	
2d	Was the condition due to pregnancy, infertility or childbirth?	Yes ☐ No☐
	If YES, please state date of commencement of pregnancy, or date of first treatment for infertility:	
2e	Was the condition a congenital anomaly; a physical defect	Yes ☐ No☐
	at birth; a genetic condition? If YES, please specify:	
2f	Was the condition a nervous or mental disorder?	Yes ☐ No☐
	If YES, please specify:	
3a	When did the patient first consult you for this condition:	Date:
3b	Did patient have any symptoms related to this condition prior to consulting you?	Yes ☐ No☐
3c	How long had the patient been troubled by symptoms prior to consulting you?	
3b	Has patient ever had the same or similar condition or symptoms relating thereto? If YES, please state when and describe:	Yes ☐ No☐
3e	How long has the above sickness or injury existed?	
3f	Doctors previously consulted by patient for the above condition? Name:	
	Approximate Date:	
	Name of Clinic:	
	Address/Tel No:	
4a	Name and nature of surgical or obstetrical procedure (if any):	
4b	Is surgery for cosmetic reason?	Yes ☐ No☐
4c	Date performed:	Date:
5	Is patient still under your care for this condition? If NO, please give date service terminated:	Yes ☐ No☐ Date:
6a	What is the prognosis of this illness?	
6b	Is the above condition likely to relapse or require long term care? If so, what treatment is required:	
7a	Period of Hospitalisation:	Date Admitted: / Date Dischared:
7b	Name/Address of Hospital: Name:	
	Address:	
8	Is patient fit to travel with such medical problem? If NOT, estimated duration patient remains unfit to travel:	Yes ☐ No☐

Name of Attending Phsician:

Date:

Address & Offical Stamp:

HCF/2002-2

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