Important Information

This claim form is to facilitate your claim in the event of you or a member of your family being confined to hospital while being insured under a Hospital Income policy.

You can help to avoid unnecessary delay in processing your claim by ensuring that:

1) Sections A to E are fully completed and signed by the Insured and/or Claimant.

2) Section F is completed by the Claimant’s Attending Physician. Please note that you or the Claimant is responsible for any expenses incurred in obtaining medical evidence in support of the claim.

3) If you are claiming for Recuperation / Post-Hospitalisation benefits, please attach detailed Pre-Medical / Final Hospitalisation / Post-Medical Report or a copy of the Inpatient Discharge Summary to the Claim Form.

4) If you are claiming for Medical / Hospital expenses, please attach the original detailed Final Bills and Receipts.

The issue and acceptance of this form does NOT constitute an admission of liability by Chubb Insurance Singapore Limited (Chubb) or waiver of its rights.
### Section A: Particulars of Policyholder / Insured Person

**Name of Policyholder / Insured Person (as shown in NRIC / Passport)**

____________________________________________________________________________________________________________________________

**Address of Policyholder / Insured Person**

____________________________________________________________________________________________________________________________

Postal Code

**Policy No(s)**

**Period of Insurance**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD / MM / YYYY</td>
<td>DD / MM / YYYY</td>
</tr>
</tbody>
</table>

**NRIC / Passport No.**

Date of Birth | DD / MM / YYYY |

**Nationality**

Age

**Tel No. (Mobile)**

Gender | Male | Female

**Tel No. (Residence)**

Tel No. (Office)

**Email**

**Name of Intermediary (if any)**

**Name of Employer**

**Occupation**

Date of Employment | DD / MM / YYYY |

**Name of Claimant (as shown in NRIC / Passport) - if different from Insured Person**

____________________________________________________________________________________________________________________________

**Address of Claimant**

____________________________________________________________________________________________________________________________

Postal Code

**NRIC / Passport No.**

Date of Birth

**Nationality**

Age

**Tel No. (Mobile)**

Gender | Male | Female

**Tel No. (Residence)**

Tel No. (Office)

**Email**

**Relationship to Insured**

**Name of Employer**

**Occupation**

Date of Employment | DD / MM / YYYY |
Section B: Payment Details

Please provide details for payment of your claim in the event that the claim is deemed payable by Chubb.

I hereby authorise and request Chubb to pay benefit due in respect of this claim as follows (Name as per Identification Card and / or Bank Account):

☐ Cheque Payment

Payee Name (as per bank account name) __________________________________________________________

☐ Electronic Funds Transfer (for payments in SGD and to bank accounts in Singapore)

Payee Name (as per bank account name) __________________________________________________________

Name of Bank ________________________________________________________________________________

Branch Code No. __________________________ Account No. __________________________

If no name is provided, settlement will be effected to the payee as provided for under the terms of the policy.

Section C: Details of Claim

Name of Hospital __________________________________________________________

Period of Hospitalisation From DD / MM / YYYY To DD / MM / YYYY

Was the Insured referred by a General Practitioner / Specialist / Other Hospital? ☐ Yes ☐ No

If Yes, please provide details below:

Name of General Practitioner / Specialist / Hospital

__________________________________________________________________________________________________________________________________________

Address

__________________________________________________________________________________________________________________________________________

Postal Code __________________________

Please complete this portion if hospitalisation was due to accident

Date of the Accident DD / MM / YYYY Time of the Accident (24-Hour) HH : MM

Country of Accident Place of Accident

When and Who discovered the Accident __________________________

Relationship of person to the Insured __________________________

Were there witnesses to the accident? ☐ Yes ☐ No

If Yes, please provide details below:

<table>
<thead>
<tr>
<th>Witness 1</th>
<th>Witness 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>NRIC</td>
<td></td>
</tr>
<tr>
<td>Contact Number</td>
<td></td>
</tr>
</tbody>
</table>
Was the Insured under the influence of alcohol, medication, drugs or any other intoxicating substance at the time of accident?  ☐ Yes ☐ No

If Yes, please provide details below (Please use supplementary sheet if necessary):

<table>
<thead>
<tr>
<th>Name/Type of Alcohol, Medication, Drugs or Intoxicating Substances</th>
<th>Quantity Consumed</th>
<th>Date And Time Consumed</th>
</tr>
</thead>
</table>

Nature of Injury (e.g. fracture, cut, bruises, etc)

Chronology and Description of the Accident (Please use supplementary sheet if necessary)

_____________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________

Please complete this portion if hospitalisation was due to an illness

Details of the Medical Practitioner who is currently treating the Insured

Name of Clinic / Hospital ___________________________ Name of Doctor ___________________________

Address

_____________________________________________________________________________________________________________________________

______________________________________________

Postal Code ___________________________

Tel / Fax ___________________________

Nature of Illness (describe the symptoms suffered)

_____________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________

Date of Symptoms First Noticed  DD/MM/YYYY

Date of First Consultation with a Medical Practitioner for this Condition  DD/MM/YYYY

Describe the symptoms presented during the first consultation

_____________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________

Has the Insured ever seen a doctor for any similar condition in the past?  ☐ Yes ☐ No

If Yes, please provide details of the Clinic / Hospital

Name of Clinic / Hospital ___________________________ Name of Doctor ___________________________

Address

_____________________________________________________________________________________________________________________________

______________________________________________

Postal Code ___________________________

Tel / Fax ___________________________
Section D: Any Other Claims / Insurance

Have you claimed or are there any other insurance policies that cover or may provide cover for hospitalisation, whether for this incident or in the past? If Yes, state:

<table>
<thead>
<tr>
<th>Name of Insurance Company</th>
<th>Policy No.</th>
<th>Type of Policy</th>
<th>Date Policy Effected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Are you claiming from any other insurance company or other sources in respect of injury or illness? If Yes, state:

<table>
<thead>
<tr>
<th>Name of Insurance Company</th>
<th>Policy No.</th>
<th>Amount of Benefits</th>
<th>Date Policy Effected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

Section E: Declaration

Did you remember to enclose the following? (Where applicable)

<table>
<thead>
<tr>
<th>Document</th>
<th>Yes</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traffic Police Report (if involved in Road Accident)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copy of Final Hospital Bill</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Written notes from Physician on type of injury sustained / Inpatient Discharge Summary or Medical Report</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

By signing this form, I/We agree that Chubb will use the information supplied here and during the formation and performance of this policy, for policy administration, customer services, claims handling and fraud analysis and prevention, and that Chubb may disclose such information to its service providers, agents, authorities and other parties for these purposes.

I/We hereby authorise any hospital, physician, and any other person or entity who has attended to or examined the Insured, to furnish to Chubb or its authorised representatives, any and all information with respect to any illness or injury or loss, medical history, consultation, prescriptions or treatment, copies of all hospital, medical or other records, investigation status and results, and such personal information as Chubb in its absolute discretion considers relevant for its assessment of this claim. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

I/We do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I/We agree that if I/We have made or in any further declaration or representation shall make any false or fraudulent statements or suppress, conceal or falsely state any fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past, present or future claims shall be forfeited.

___________________
Signature of Claimant

___________________
Signature of Insured Person (if different from Claimant)

Date

Note:
Kindly submit the completed claim form in person or by mail to Chubb Insurance Singapore Limited at 138 Market Street #11-01 CapitaGreen Singapore 048946. Please ensure that the relevant original copies of supporting documents are submitted as well.

Contact Us
Chubb Insurance Singapore Limited
Co Regn. No.: 199702449H
138 Market Street
#11-01 CapitaGreen
Singapore 048946
065 6398 8000
F 65 6298 1055
www.chubb.com/sg
Section F: Attending Physician’s Statement (To be completed by attending physician)

Name of Patient ____________________________

NRIC / Passport No. ____________________________ Gender □ Male  □ Female  Date of Birth DD / MM / YYYY

If Injury, when did Accident occur? DD / MM / YYYY  If Sickness, when did symptoms first occur? DD / MM / YYYY

State the Nature of Injury or Sickness (Describe the complications - if any)

______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Final Diagnosis ____________________________ Nature of Surgery (if any) ____________________________

If there is more than one diagnosis, please advice whether they are directly or indirectly related to each other. (Please provide details)

______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

When did the Patient first received medical attention for this condition? DD / MM / YYYY

By who and where? (Please provide details below)

Name of Clinic / Hospital ____________________________________________________________________________

Address ____________________________________________________________________________________________

Name of Doctor ______________________________________________________________________________________

Has the Patient ever had this or any similar condition? □ No  □ Yes (Please provide details below)

______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

What was the underlying cause(s) of the diagnosed condition(s)?

______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Did the Patient receive any treatment for the condition(s) prior to consulting you? □ No  □ Yes

If 2 or more surgical procedures were performed, were they performed through a single incision? □ No  □ Yes

Is the present condition due to:

- congenital anomaly? □ No  □ Yes (Please specify) ___
- nervous or mental disorder? □ No  □ Yes (Please specify) ___
- pregnancy/childbirth/infertility? □ No  □ Yes (Please specify) ___
- alcohol influence? □ No  □ Yes (Please specify) ___

Were the condition(s) or treatment directly or indirectly related to each other? (Please provide details)

______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
Name of Hospital admitted ____________________________________________

Address of Hospital admitted ____________________________________________

Period of Hospitalisation From DD / MM / YYYY To DD / MM / YYYY

Are you the Patient’s usual doctor? ☐ No ☐ Yes

If No, please provide details of the usual doctor

Name of Doctor ____________________________________________ Tel / Fax ____________________

Address of Doctor ____________________________________________

Has the Patient fully recovered from the condition(s)? ☐ No ☐ Yes

If No, please provide details of the follow-up treatment(s) required

_____________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________

I hereby certify that I have personally examined and treated the patient for the above injury/sickness and that the facts as given above present my opinion of his / her condition.

Name of Physician ____________________________ Qualification / Field of Expertise ____________________________

Official Address ____________________________________________

Tel / Fax ____________________________

Signature with Official Stamp ____________________________ Date ____________________________

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