LIFE INSURANCE CORPORATION (SINGAPORE) PTE LTD

Life Insurance Corporation(Singapore)Pte Ltd
3 Raffles Place,#07-01,Bharat Building,
Singapore 048617, Phone:-+6562234797
email ID:-crm@licsingapore.com

CRITICAL ILLNESS CLAIM FORM: PART 1- CLAIMANT'S STATEMENT

INSTRUCTIONS

This form is to be completed by the life assured. If the life assured is aged below 18, then the proposer should fill this form.

The cost for the medical specialist's statement and other hospital records are to be borne by the claimant.
Please submit the forms and documents to our office in the address mentioned here.

A. POLICY DETAILS		
Policy Number(s)		
B. PARTICULARS OF THE LIFE ASSURED		
Name of the Life Assured	Date of Birth (dd/mm/yyyy)	NRIC No. (If life assured is not a Singapore Citizen, please provide FIN / Passport No.)
C.PARTICULARS OF THE CLAIMANT (if other than the life assured)		
Name of the Claimant	Contact Number	NRIC No. (If claimant is not a Singapore Citizen, please provide FIN / Passport No.)
Claimant's Address	Relationship to the life assured	Capacity / Title under which the claim is made.

D. TYPE OF CRITICAL ILLNESS		
☐ Alzheimer's Disease	☐ Aplastic Anaemia	☐ Angioplasty and Other Invasive Treatment for Coronary Artery
☐ Bacterial Meningitis	☐ Benign Brain Tumour	☐ Blindness (Loss of Sight)
☐ Coma	☐ Coronary Artery By-Pass Surgery	☐ Deafness (Loss of Hearing)
☐ Encephalitis	☐ End Stage Liver Disease	☐ End Stage Lung Disease
☐ Fulminant Hepatitis	☐ Heart Attack	☐ Heart Valve Surgery
☐ HIV due to Blood Transfusion and Occupationally Acquired HIV	☐ Kidney Failure	☐ Loss of Speech
☐ Major Burns	☐ Major Cancers	☐ Major Organ / Bone Marrow Transplantation
☐ Motor Neurone Disease	☐ Multiple Sclerosis	☐ Muscular Dystrophy
☐ Major Head Trauma	☐ Paralysis (Loss of limbs)	☐ Parkinson's Disease
☐ Primary Pulmonary Disease	☐ Stroke	☐ Surgery to Aorta

E. TREATMENT PARTICULARS	
1.The date when the critical illness was first diagnosed	_____/____/_____ (dd/mm/yyyy)
2.The date when a physician was first consulted for the illness.	_____/____/_____ (dd/mm/yyyy)
3.Have the claimant had the same or similiar conditions or treatment earlier? If Yes,give details.	
4.Please give details of investigations or tests undergone in connection with the illness.	

5.Details of the attending physicians for this illness . Please attach a separate sheet if additional space is required.

Name of the Doctor	Name and Address of Clinic / Hospital	Date of consultation	Purpose of Visit

F . IF ILLNESS IS DUE TO ACCIDENT			
1.Please state the place ,Date and time of the accident	Place of Accident	Date of Accident (dd/mm/yyyy)	Time of Accident
2. Description of the Accident			
3.Was the accident reported to the police?	☐ Yes ☐ No	If 'Yes', submit a certified copy of the Police Investigation Report	

G.OTHER INSURANCE DETAILS: Please attach a separate sheet if additional space is required.

Is the life assured insured with other companies for similar benefits?	☐ Yes ☐ No . If 'Yes', please give details below				
Name of the Company	Policy Number	Date of Issue (dd/mm/yyyy)	Sum Insured (S$)	Date of intimation of claim	Status of the claim

H. DECLARATION BY THE CLAIMANT

1.I, _____ hereby declare that the above statements are true and complete and that I have not withheld any material fact from Life Insurance Corporation and I make this solemn declaration believing it to be true and by virtue of the provisions of the Statutory Declaration Act,1835.

2.I hereby consent to Life Insurance Corporation from seeking information from any hospital,physician,person or organisation that maybe required regarding the life assured and I authorise the giving of such information to Life Insurance Corporation. A photocopy of this authorisation shall be considered as valid as the original.

_____ _____

Date(dd/mm/yyyy) Signature of the Claimant

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CRITICAL ILLNESS CLAIM FORM: PART 2 - PHYSICIAN'S STATEMENT

To be completed by the attending Medical specialist. Please attach all relevant investigation reports
The cost of the reports will be borne by the patient / claimant of the insurance policy.

1. Name of the patient	NRIC / Passport number	Occupation
2.The date when the patient first consulted you for this condition _____/___/_____ (dd/mm/yyyy)		
3.The date when the condition was first diagnosed _____/___/_____ (dd/mm/yyyy)		
4. What is the diagnosis of the condition?		
5. Has the patient ever had a similar condition earlier? If Yes, give details.		
6. What is the cause for this condition?		
6. Give details of treatment / surgical procedures carried out.		

7. What investigations were conducted for the diagnosis / treatment?

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8. Give the details of all the doctors/ hospitals the patient has been to in connection with this condition

9. List of clinical, histological and laboratory reports attached:

Name of the Doctor:_____

Qualification : _____

Signature : _____

Date: : _____ Hospital / Official Stamp