INDIVIDUAL HOSPITAL & SURGICAL CLAIM FORM

Dear claimant,

We are sorry to learn about your hospitalization.

In order for us to process your claim, we require the following:

(1) Claimant's Statement
(2) Doctor's Statement (refer to Note A below)
(3) Consent Form For Medical Report
(4) Original final hospital bills (refer to Note B below)
(5) Detailed hospital bills are required for admission to private hospitals
(6) Copy of CPF Statement or Medisave deduction notification showing the Hospital Registration Number (HRN) if you have used Medisave for the hospital bill
(7) Copy of police report (if injury is due to a road traffic accident)
(8) Copy of physical NRIC of claimant and life assured
(9) Proof of relationship for 3rd party policies
(10) All documents which are in foreign language must be officially translated to English (translated by official Authority / Notary Public / Embassy) before submitting to us.

Once we have received **all** the above required documents, we will process your claim and inform you of the outcome as soon as possible.

Note:

(A) For claims that are less than $1,000 or less than the deductible amount for policies with deductible, we may consider waiving the medical report if there is sufficient documentary evidence, such as the Inpatient Discharge Summary showing the cause of disability/illness, period of disability/illness and hospitalization. If necessary, a medical report would still be required for claims that are less than $1,000.

For claims that are more than $1,000, the original medical report must be submitted together with the claims documents for processing.

Medical report is compulsory if hospitalization or day surgery is performed overseas.

Medical Report fee to be borne by Policyholder.

(B) Copy of hospitalization bills will be accepted for hospitalization benefit claims. Original final hospital bill is required for reimbursement benefit claims.

Submission of Claim Documents

Please submit all claim documents:

(I) Through your servicing adviser; OR

(II) By post to the below address:

Life Claims Department
Tokio Marine Life Insurance Singapore Ltd
20 McCallum Street
#07-01 Tokio Marine Centre
Singapore 069046

(2024.03)

INDIVIDUAL HOSPITAL & SURGICAL CLAIM
CLAIMANT'S STATEMENT

IMPORTANT NOTES :
(1) The issue of this claim form is not an admission of liability
(2) This claim form is to be completed by the Assured
(3) This claim form is used for submission of both Hospital & Surgical and Hospitalization Benefit Claim
(4) Tokio Marine Life Insurance Singapore Ltd. reserves the right to request for additional medical reports when it deems necessary

PART 1 : DETAILS OF POLICY(IES)

1.1 Policy No. : (a) ______________ (b) ______________

(c) ______________ (d) ______________

PART 2 : DETAILS OF ASSURED

2.1 Name : ______________________________
(as stated in NRIC / Passport)

2.2 NRIC / Passport No. : ______________________________

2.3 Residence address : ______________________________

2.4 Occupation : ______________________________

2.5 Contact No. : __________ (H) __________ (O) __________ (HP)

PART 3 : DETAILS LIFE ASSURED [if different from Part (2)]

3.1 Name : ______________________________
(as stated in NRIC / Passport)

3.2 NRIC / Passport No. : ______________________________

3.3 Residence address : ______________________________

3.5 Contact No. : __________ (H) __________ (O) __________ (HP)

PART 4 : DETAILS OF LIFE ASSURED'S OCCUPATION

4.1 Occupation : ______________________________

4.2 Name of employer : ______________________________

4.3 Address of employer : ______________________________

4.4 Description of duties : ______________________________

______________________________ ______________________________

Signature of Assured Date (dd/mm/yyyy)

(2024.03)

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Singapore: 20 McCallum Street, #07-01 Tokio Marine Centre, Singapore 069046 T: (65) 6592 6100 F: (65) 6223 9120 W: tokiomarine.com
Brunei: Unit 2, 1st Floor, Blk D, Abdul Razak Complex, Gadong, Bandar Seri Begawan BE4119, Brunei Darussalam T: (673) 02-423 755 F: (673) 02-423 754

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PART 5 : DETAILS OF ILLNESS(ES) / MEDICAL CONDITION(S) OF LIFE ASSURED

5.1 Was the hospitalization or day surgery resulted from? ☐ Illness ☐ Accident

(a) If it was due to an illness, please provide the following information :

(i) Please describe fully the symptoms for which the Life Assured consulted a doctor :

____

____

(ii) Since when did the Life Assured have the symptoms before he / she consulted a doctor? ______________ (dd/mm/yyyy)

(iii) Date when the Life Assured **first** consulted a doctor? ______________ (dd/mm/yyyy)

(iv) Describe fully the extent and nature of the illness or injury :

____

(b) If it was due to an accident, please provide the following information :

(i) Date of accident : ______________ (dd/mm/yyyy) Time of accident : ______________

Place of accident : ____________________________

(ii) Describe in detail how the accident happened :

____

____

(iii) Please describe the nature and extent of injuries sustained :

____

____

(iv) Was there any eye-witness to the accident? ☐ Yes ☐ No

If **yes**, please give name(s) and address(es) of witness(es) :

Name of Witness	Address

(v) Was the accident reported to the police? ☐ Yes ☐ No

If **yes**, please give the name of the police station reported to (please enclose a copy of the police report) :

____

6.1 Details of hospitalization / day surgery :

Name of hospital	Name of attending doctor	Date of hospitalization

____________________ ____________________

Signature of Assured Date (dd/mm/yyyy)

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6.2 Please provide details of doctor(s) whom the Life Assured has consulted in connection to his / her illness :

Name of doctor / hospital	Address	Date of first consultation / hospitalization

6.3 Please provide details of the Life Assured's regular doctor, date & reason of consultation :
Name(s) and address(s) of the Life Assured's regular doctor(s) :

Name of doctor	Address	Date of consultation	Reason(s) for consultation

PART 7 : OTHER INSURANCES

7.1 Was the Life Assured insured with other insurance company(ies)? ☐ Yes ☐ No
If **yes**, please provide the following details :

Name of insurance company	Date of issue	Sum assured	Type of plan	Claim amount	Claim notified
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Signature of Assured

Date (dd/mm/yyyy)

(2024.03)

PART 8: DECLARATION FOR COMMON REPORTING STANDARD (CRS)

8.1 Please provide information on your Tax Residency. (This will usually be where you are liable to pay income taxes.)

	Country of Tax Residence	Taxpayer Identification Number (TIN) In Singapore, TIN for Individuals would be your NRIC/FIN	If no TIN available, enter Reason A, B or C	Please state reason(s) if Reason B is selected
Proposer				
Joint Life Assured				

If you are a tax resident in more than two countries, please use a separate Individual Tax Residency Self-certification Form.
If a Taxpayer Identification Number (TIN) is unavailable, please provide the appropriate reason A, B or C:
Reason A The country where you are liable to pay tax does not issue TINs to its residents.
Reason B You are otherwise unable to obtain a TIN or equivalent number (Please explain why you are unable to obtain a TIN in the below table if you have selected this reason).
Reason C No TIN is required. (Note: Only select this reason if the authorities of the country of tax residence entered below do not require a TIN to be disclosed).

For more information on Common Reporting Standard, you can refer to our company website. (http://www.tokiomarine.com/sg/en/about-us/crs.html)

For Entity and/or Controlling Persons, please complete the Entity Tax Residency Self-Certification Form and/or Controlling Person Tax Residency Self-Certification Form (forms can be obtained from the same website). If you have any questions on how to define your tax residency status, please visit the IRAS website or speak to a professional tax adviser as we are not allowed to give tax advice.

Signature of Assured

Date (dd/mm/yyyy)

(2024.03)

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Personal Data Notice
I / We agree and consent that Tokio Marine Life Insurance Singapore Ltd. and Tokio Marine Insurance Singapore Ltd. ("Tokio Marine Insurance Group") may collect, use, process and disclose the personal data in accordance with the terms and conditions as stated in the insurance application form and/or the Tokio Marine Insurance Group's Data Protection Policy available at www.tokiomarine.com which I / we have read, understood and agreed to the same.

Declaration

I agree that:-

(i) all answers and information given by me in this form are true and correct to the best of my knowledge, information, and belief;

(ii) I have neither withheld any material information nor omitted any relevant circumstances in respect of my illness, condition or accident;

(iii) the documents and bills submitted in support of my claim are either originals or scanned copies of the originals which are genuine documents received from the medical institution(s), and if scanned copies are submitted, I undertake to produce the original copies once requested of me;

(iv) If the answers and information given are not complete and Tokio Marine Life Insurance Singapore Ltd ("TMLS") requires additional information and/or documents, I undertake to provide the same to their satisfaction;

(v) I did not and will not file duplicate claims in regards to the subject matter for this claim with any other parties;

(vi) TMLS reserves the right to reject this claim, recover all amounts paid and/or impose additional charges on me, if the answers and information provided in this claim are found to be fraudulent, or if duplicate claims filed with any other parties. In such case, I will indemnify TMLS as to all their expenses, costs, and charges (including but not limited to any legal fees) in regards to their time, effort and attention to this claim or the recovery of any amounts paid, which I will recognize is a debt due and owing to TMLS;

(vii) TMLS shall not be deemed to have provided cover and neither should TMLS be liable to pay any claim, provide any benefit under the Policy/relevant Policy or be required to process any request made to the extent that the provision of such cover, payment of such claim, provision of such benefit or processing of such request would directly and/or indirectly expose TMLS (or its parent company or holding company or the subsidiaries of its parent or holding company) to any sanction, prohibition or restriction under International Law, United Nations resolutions or the trade or economic sanctions, laws or regulations of any applicable jurisdiction, Singapore, the European Union, United Kingdom or United States of America;

(viii) where TMLS becomes aware that I, the Life Assured or any other person or entity connected with the Policy/relevant Policy is/are subject to any sanction, prohibition or restriction under such resolutions, trade or economic sanctions, laws or regulations mentioned above, TMLS shall be entitled to block, suspend and/or terminate the Policy/relevant Policy at any time including but not limited to, not making or receiving any payments under the Policy/relevant Policy. The decision of TMLS on the aforementioned is final; and

(ix) a person or entity connected with the Policy/relevant Policy includes an assignee, a beneficiary, a trustee, an executor, an administrator, a director or direct/indirect shareholder or person having executive authority or natural persons appointed to act on my behalf, for my beneficial owners or beneficiaries' beneficial owners. As an ongoing obligation, I will immediately inform TMLS if there are any changes to the identities, status/constitution/establishment, particulars and identification documents of these persons.

I hereby authorize:

(a) any medical source, insurance office, and/or organization when requested to do so by TMLS, to release any and all requested documents, or categories of documents and information concerning the answers provided herein, and in respect to my illness, condition and/or accident for which I have made this claim; and

(b) TMLS to release to any medical source, insurance office, or organization, any relevant information concerning myself and the answers provided herein at any time.

I confirm and agree that a photocopy of this authorization shall have the same effect as the original.

Signature of Assured	Date

Name(s) : ____________________

NRIC No(s) : ____________________

Address(es) : ____________________

(Note: Our correspondence will be sent to your policy's mailing address. If you have moved, please update your mailing address via TMLS Policyholders Portal https://mypolicy.tokiomarine-life.sg before submitting this claim.)

Email Address : ____________________

Contact No(s) : (HP) ____________________

Relationship to Life Assured : ____________________

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INDIVIDUAL HOSPITAL & SURGICAL CLAIM DOCTOR'S STATEMENT

1 Name of patient : ______________________________
(as stated in NRIC / Passport)

2 NRIC / Passport No. : ______________________________

3 **DETAILS OF CONSULTATION / TREATMENT**

(a) Diagnosis : ______________________________

(b) Date of the patient's first consultation with you : ______________________________
(dd/mm/yyyy)

(c) Please state symptoms presented and date symptoms first appeared in the box provided below :

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

(d) Date of diagnosis : ______________________________
(dd/mm/yyyy)

(e) Diagnosis was first made by (Name of Doctor) : ______________________________

(f) Date when diagnosis was first made known to the patient : ______________________________
(dd/mm/yyyy)

(g) Date when the patient first became aware of symptoms : ______________________________
(dd/mm/yyyy)

(h) In your opinion, how long do you think the illness / condition has existed? ______________________________

(i) Please provide full details of all treatment provided and the response :

____

____

(j) Was the treatment related to the following conditions?

(i) Congenital conditions / physical defect at birth? ☐ Yes ☐ No
(ii) Nervous mental disorder / related to state of mind? ☐ Yes ☐ No
(iii) Treatment of teeth / gum tissue / oral mucosal? ☐ Yes ☐ No
(iv) Job-related injuries? ☐ Yes ☐ No

______________________________ ______________________________

Hospital / Clinic Stamp | Signature of Attending Doctor

Date (dd/mm/yyyy) ______________________________

Name and Address

Qualification

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(v) Sexually transmitted disease, AIDS and all illnesses or diseases related to HIV? ☐ Yes ☐ No

(vi) Complications arising from pregnancy, childbirth, abortion, miscarriage, impotency, sterilization, birth control measures or infertility? ☐ Yes ☐ No

If **yes**, when was the commencement date? ____________ (dd/mm/yyyy)

(vii) Alcoholism or drug abuse? ☐ Yes ☐ No

(viii) Cosmetic or plastic surgery? ☐ Yes ☐ No

(ix) Is the surgery medically necessary? ☐ Yes ☐ No

If any of the answers to Questions 3(a) – (ix) is **yes**, please provide full details :

____

____

(k) Was surgery performed for this condition? ☐ Yes ☐ No
If **yes**, please specify :

Type of surgical operation performed	Date of surgery (dd/mm/yyyy)	Surgical table code(s)

(l) Please state the period of hospitalization :

Name of doctor / hospital	Address	Date of hospitalization

(m) Is the patient scheduled for further surgery? ☐ Yes ☐ No
If **yes**, please specify the tentative date of surgery : ____________ (dd/mm/yyyy)

4 DETAILS OF ACCIDENT

Was the condition the result of an accident? ☐ Yes ☐ No

If **yes**, please provide the following details.

(a) Date of accident : ____________ (dd/mm/yyyy) Time of accident : ____________

Place of accident : ______________________________

Hospital / Clinic Stamp

Date (dd/mm/yyyy) ____________

Signature of Attending Doctor

Name and Address

Qualification

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(b) Describe in details how the accident happened :

____

____

(c) Please describe in details the nature and extent of injuries / disabilities :

____

____

(d) Were the injuries / disabilities the result of the accident described above? ☐ Yes ☐ No

(e) Was the patient under the influence of alcohol or drugs at the time of accident? ☐ Yes ☐ No

(f) Was the cause of the patient's condition / injury a result of self-destruction / intentional self-infliction? ☐ Yes ☐ No
If **yes**, please provide full details :

____

____

5 **MEDICAL HISTORY**

(a) Has the patient previously suffered from the same illness? ☐ Yes ☐ No
If **yes**, please provide the following :

(i) Date when the illness is first diagnosed : ______________ (dd/mm/yyyy)

(ii) Name and address of the doctor who first treated the patient :

____

(iii) Name(s) and address(es) of the attending doctor(s) :

____

____

(iv) Has the patient been admitted to any hospital or treated before, either for the same or different cause? ☐ Yes ☐ No
If **yes**, please state :

Name of doctor	Name of hospital	Diagnosis	Date of hospitalization

______________________________ Hospital / Clinic Stamp

Date (dd/mm/yyyy) ______________

______________________________ Signature of Attending Doctor

Name and Address

Qualification

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(b) Are you the patient's regular doctor? ☐ Yes ☐ No

If **yes**, since when : ______________ (dd/mm/yyyy)

If **no**, kindly provide the name and address of his / her regular doctor, if known to you :
Name of doctor / specialist :

Address of clinic :

(c) Was the patient being referred to you? ☐ Yes ☐ No

If **yes**,

(i) Please provide the date of referral ______________ (dd/mm/yyyy)

(ii) Please provide the name and address of the referral doctor :

(d) Is the patient being referred to another doctor for follow-up? ☐ Yes ☐ No

If **yes**, please provide the following :

(i) Name and address of the doctor :

(ii) Reason for the referral :

(e) Is the patient suffering from other significant illness(es) / condition(s)? ☐ Yes ☐ No

If **yes**, kindly provide the details below :

Illness / Condition	Date of first consultation	Name of hospital / doctor	Address

6 Kindly provide us with additional information, if any, to further assist us in assessing this claim :

Hospital / Clinic Stamp

Date (dd/mm/yyyy) ______________

Signature of Attending Doctor

Name and Address

Qualification

(2024.03)

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CONSENT FORM FOR MEDICAL REPORT

NAME OF PATIENT : ______________________________

NRIC NO. : ____________________ POLICY NO. : ____________________

This consent form is required for an insurance claim.

Authorization

I hereby authorize:

(a) any medical source, insurance office, and/or organization when requested to do so by Tokio Marine Life Insurance Singapore Ltd ("TMLS"), to release any and all requested documents, or categories of documents and information concerning the answers provided herein, and in respect to my illness, condition and/or accident for which I have made this claim; and

(b) TMLS to release to any medical source, insurance office, or organization, any relevant information concerning myself and the answers provided herein at any time.

I confirm and agree that a photocopy of this authorization shall have the same effect as the original.

Yours faithfully

____
Signature of *Patient / Patient's Parent / Next-Of-Kin

Name : ______________________________

Address : ______________________________

____

NRIC No. : ____________________ Relationship to patient : ____________________

* delete accordingly

(2024.03)

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AUTHORISATION FORM FOR CREDITING TO SINGAPORE BANK ACCOUNT

Policy No	
Type of Payment	Claims

Please select ONE option:

☐ **PayNow registered with Singapore NRIC/FIN**

- Please note that PayNow account registered with mobile number is not accepted.
- You may register for PayNow account using your Singapore NRIC/FIN via “Manage Paynow” in your internet banking or mobile banking application.
- If the PayNow transaction is unsuccessful, we will send you a cheque to your mailing address.

☐ **Electronic Fund Transfer to your Singapore Bank Account**

- Please attach a copy of your bank statement/passbook showing your name and bank account no. We accept bank statements with balance/transactions masked. Truncated e-statements downloaded from banks’ mobile application are also acceptable as long as the document shows the account holder’s name and account number on the same page.

Name of Singapore Bank	
Account No	
Bank Account Holder’s Name	

Declaration & Authorisation

I/We Hereby Authorise Tokio Marine Life Insurance Singapore Ltd to Credit The Amounts Due To Me/Us To The Above Requested Paynow/Bank Account, Where Applicable. Amounts so credited would constitute valid discharge of above payment due to me/us.

I/We understand and agree that:

a) Where I/we are eligible to receive payments from Tokio Marine Life Singapore Ltd (“TMLS”) for policy proceeds (“Payment”) as determined by TMLS, the Payment will either be credited to my/our bank account linked to my/our Singapore NRIC/FIN, which I/we have registered with a bank for PayNow or bank transfer (depending on option chosen above). For avoidance of doubt, Payment is not applicable to PayNow linked to your mobile or company UEN.

b) By completing this form, I/we declare it is my/our responsibility to ensure that all information submitted herein is correct and complete to the best of my/our knowledge. TMLS is not obliged to ensure that all information provided by me/us herein is accurate or that it remains true and accurate at the time of processing the Payment.

c) PayNow or the bank transfer service is not operated by TMLS and my/our access to and use of PayNow or for a bank transfer is subject to the availability of PayNow and their services and that of my/our bank for the bank transfer. TMLS does not warrant my/our use of PayNow or for a bank transfer and the use is subject to the relevant terms and conditions of PayNow and/or my/our bank.

d) I/we shall indemnify TMLS against all costs, damages and/or losses arising from or in connection with any breach by me/us of these terms or the terms and conditions imposed by my/our bank in relation to a bank transfer, or PayNow, or their service provider, my/our bank.

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A member of the Tokio Marine Group

e) TMLS shall bear no liability to me/us or any other party in the event the Payment is not made into my/our bank account otherwise, or the Payment being late, unsuccessful, or incomplete, or the suspension, termination, or discontinuance of PayNow or their services.

f) TMLS has the sole discretion to make Payment using any other method as it deems fit and TMLS shall be entitled to terminate or suspend the Payment of your policy proceeds to me/us, and/or to add to, delete, or change the terms herein at any time without notice, without liability to me/us.

g) TMLS shall not be deemed to provide cover and neither should TMLS be liable to pay any claim, provide any benefit under the Policy/relevant Policy or be required to process any request made to the extent that the provision of such cover, payment of such claim, provision of such benefit or processing of such request would expose TMLS (or its parent company or holding company (in both instances, whether direct or indirect) or the subsidiaries of its parent or holding company) to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the applicable jurisdiction, Singapore, the European Union, United Kingdom or United States of America.

h) Where TMLS becomes aware that I/We, the Life Assured or any person or entity connected with the Policy/relevant Policy (see paragraph below) is/are subject to any sanction, prohibition or restriction under such resolutions, trade or economic sanctions, laws or regulations mentioned in the paragraph above, TMLS shall be entitled to block, suspend and/or terminate the Policy/relevant Policy at any time including but not limited to, not making or receiving any payments under the Policy/relevant Policy. The decision of TMLS on the aforementioned is final.

i) A person or entity connected with the Policy/relevant Policy includes an assignee, a beneficiary, a trustee, an executor, an administrator, a director or direct/indirect shareholder or person having executive authority or natural persons appointed to act on my/our behalf, for my/our beneficial owners or beneficiaries' beneficial owners. As an ongoing obligation, I/We will immediately inform TMLS if there are any changes to the identities, status/ constitution/ establishment, particulars, and identification documents of these persons.

j) A person who is not a party to this agreement shall have no right under the Contracts (Rights of Third Parties) Act 2001 to enforce any of these terms.

k) These terms shall be governed by the laws of Singapore and the exclusive jurisdiction of the Courts of Singapore.

Personal Data Notice
I / We agree and consent that Tokio Marine Life Insurance Singapore Ltd. may collect, use, process and disclose the personal data in accordance with the terms and conditions as stated in the insurance application form and/or the Tokio Marine Insurance Group's Data Protection Policy available www.tokiomarine.com which I / we have read, understood and agreed to the same.

Signature of Assured	Date

Name: ______________________ NRIC No: ______________________

Email: ______________________ Mobile No: ______________________

(2024.03)

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