TOKIO MARINE
INSURANCE GROUP

INDIVIDUAL DREAD DISEASE / CRITICAL ILLNESS / TERMINAL ILLNESS CLAIM FORM

Dear claimant,

We are sorry to learn about your illness.

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

(1) Claimant's Statement
(2) Doctor's Statement (medical fee to be borne by policyholder)
(3) Declaration of Beneficial Ownership (for Trust / Keyman Policy)
(4) Authorisation Form For Medical Report
(5) Authorisation Form For Crediting to Singapore Bank Account
(6) Copy of physical NRIC of claimant and life assured
(7) Proof of relationship for 3rd party policies
(8) Histopathological / biopsy reports (for Cancer)
(9) ECG reading, cardiac enzymes assays & troponin reports (for Heart Attack)
(10) CT scan / MRI scan results (for Stroke)
(11) Available laboratory and test results
(12) Documents which are in foreign language must be officially translated to English (translated by official Authority / Notary Public / Embassy) before submitting to us
(13) Documents extracted from overseas must be certified true copy by Notary Public
(14) Documents signed overseas must be submitted to us in originals

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

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 Pte. Ltd.
20 McCallum Street
#07-01 Tokio Marine Centre
Singapore 069046

Note:

(a) This form is to be completed for making a claim of benefits under Dread Disease / Critical Illness, EarlyCare, CancerCare, MultiCare and Terminal Illness.

(b) Critical Illness was formerly known as Dread Disease in our policy contract.

TOKIO MARINE
INSURANCE GROUP

INDIVIDUAL DREAD DISEASE / CRITICAL ILLNESS / TERMINAL ILLNESS 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) Tokio Marine Life Insurance Singapore Pte. Ltd. reserves the right to request for additional medical reports when it deems necessary.

CLAIMANT'S STATEMENT : TO BE COMPLETED BY ASSURED

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 : _____

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 : _____

3.4 Occupation : _____

3.5 Contact no. : _____ (H) _____ (O) _____ (HP)

PART 4 : DETAILS OF ILLNESS(ES) / MEDICAL CONDITION(S) OF LIFE ASSURED

4.1 Describe fully the symptoms experienced for which the Life Assured consulted a doctor :

_____

4.2 When did the symptoms first appear before the Life Assured consulted a doctor?

_____
(dd/mm/yyyy)

4.3 Date when the Life Assured **first** consulted a doctor for the above symptoms :

_____
(dd/mm/yyyy)

4.4 If consultation was for illness, describe fully the nature and extent of the Life Assured's Illness :

_____

_____

_____ _____

Signature of Assured Date (dd/mm/yyyy)

(2025.10)

Tokio Marine Life Insurance Singapore Pte. Ltd. (Company Reg. No.: 194800055D)
20 McCallum Street #07-01 Tokio Marine Centre Singapore 069046 T: (65) 6592 6100 F: (65) 6223 9120 W: tokiomarine.com

4.5 If consultation was due to an accident, describe fully the nature of the Life Assured's injuries and how it happened :

4.6 Has the Life Assured previously suffered from or received treatment for a similar / related illness? ☐ Yes ☐ No
If **yes**, please provide details :

PART 5 : DETAILS OF MEDICAL CONSULTATIONS / HOSPITALISATION

5.1 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 / hospitalisation

5.2 Please provide details of the Life Assured's regular doctor(s), date and reason(s) of consultation :

Name of doctor/ Name of clinic	Address	Date of first consultation	Date of last consultation	Reason(s) for consultation

PART 6 : OTHERS

6.1 Has any of the Life Assured's family members suffered from a similar / related illness? ☐ Yes ☐ No

Relationship	Nature of illness	Date of diagnosis (mm/yyyy)	Age at onset

6.2 Does the Life Assured smoke cigarette? ☐ Yes ☐ No
If **yes**, what is the Life Assured's daily consumption? _____ Sticks
How long has the Life Assured been smoking? _____ years _____ months

Signature of Assured

Date (dd/mm/yyyy)

(2025.10)

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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

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)

(2025.10)

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20 McCallum Street #07-01 Tokio Marine Centre Singapore 069046 T: (65) 6592 6100 F: (65) 6223 9120 W: tokiomarine.com

Personal Data Notice

I / We agree and consent that Tokio Marine Life Insurance Singapore Pte. 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 / We agree that:-

(i) all answers given by me / us in this form are, to the best of my / our knowledge and belief, true and complete;

(ii) Tokio Marine Life Insurance Singapore Pte. Ltd. ("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;

(iii) where TMLS becomes aware that I/We, the Life Assured or any person or entity connected with the Policy/relevant Policy (see paragraph (iv) below) is/are subject to any sanction, prohibition or restriction under such resolutions, trade or economic sanctions, laws or regulations mentioned in paragraph (ii), 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

(iv) 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.

I / We hereby also authorize:

(a) any medical source, insurance office, or organization to release to or when requested to do so by TMLS, any relevant information concerning the below-named assured, and;

(b) TMLS to release to any medical source, insurance office, or organization, any relevant information concerning the below-named assured, at any time.

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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Name of Patient : _____
NRIC / Passport No : _____

TOKIO MARINE
INSURANCE GROUP

INDIVIDUAL DREAD DISEASE / CRITICAL ILLNESS / TERMINAL ILLNESS CLAIM DOCTOR'S STATEMENT

INSTRUCTIONS: Please tick [✓] in the appropriate box and complete the relevant sections in respect to the illness claimed. Please submit ONLY the relevant sections to us upon completion.

Tick	Illness claimed	Sections to complete
☐	Alzheimer's Disease / Severe Dementia	1 & 11
☐	Benign Brain Tumour	1 & 14
☐	Blindness (Irreversible Loss of Sight) / Optic Nerve Atrophy	1 & 15
☐	Cardiac Pacemaker / Defibrillator Insertion	1 & 3
☐	Cardiomyopathy	1 & 5
☐	Coma / Severe Epilepsy	1 & 16
☐	Coronary Artery By-pass Surgery / Angioplasty & Other Invasive treatment for Coronary Artery / Other Serious Coronary Artery Disease	1 & 7
☐	Crohn's Disease	1 & 44
☐	Deafness (Irreversible Loss of Hearing)	1 & 17
☐	Dengue Haemorrhagic Fever	1 & 38
☐	Diabetic Complications	1 & 35
☐	End Stage Liver Failure / Liver Disease	1 & 19
☐	End Stage Lung Disease / Severe Asthma	1 & 20
☐	End Stage Kidney Failure / Chronic Kidney Disease	1 & 24
☐	Fulminant Hepatitis / Biliary Tract Disease	1 & 22
☐	Heart Attack	1 & 2
☐	HIV Due To Blood Transfusion and Occupational Acquired HIV	1 & 23
☐	Idiopathic Parkinson's Disease	1 & 32
☐	Irreversible Aplastic Anaemia	1 & 12
☐	Irreversible Loss of Speech / Permanent Tracheostomy	1 & 25
☐	Loss of Independent Existence	1 & 43
☐	Major / Severe Burns	1 & 26
☐	Major Cancer / Carcinoma in situ / Breast Reconstructive Surgery after Mastectomy	1 & 10
☐	Major Head Trauma	1 & 40
☐	Major Organ / Bone Marrow Transplantation	1 & 27
☐	Motor Neurone Disease / Peripheral Neuropathy	1 & 28
☐	Multiple Sclerosis	1 & 29
☐	Muscular Dystrophy / Spinal Cord Disease	1 & 30
☐	Open Chest Heart Valve Surgery	1 & 6
☐	Open Chest Surgery To Aorta	1 & 8
☐	Osteoporosis	1 & 36
☐	Paralysis (Irreversible Loss Of Use Of Limbs)	1 & 31
☐	Pericardial Disease	1 & 4
☐	Persistent Vegetative Stage (Apallic Syndrome)	1 & 42
☐	Pheochromocytoma	1 & 46
☐	Poliomyelitis	1 & 21
☐	Primary Pulmonary Hypertension	1 & 33
☐	Progressive Scleroderma	1 & 41
☐	Severe Bacterial Meningitis	1 & 13
☐	Severe Encephalitis	1 & 18
☐	Severe Rheumatoid Arthritis	1 & 37
☐	Stroke with Permanent Neurological Deficit / Brain Aneurysm / Carotid Artery Surgery	1 & 9
☐	Systemic Lupus Erythematosus with Lupus Nephritis	1 & 34
☐	Terminal Illness	1 & 39
☐	Ulcerative Colitis	1 & 45
☐	Wilson's Disease	1 & 47

Please enclose copies of Histopathology / Biopsy Report (for Cancer), Serial ECG Tracings Report, Transthoracic Echocardiogram & Cardiac Biomarkers (for Heart Attack), Coronary Angiogram (for Angioplasty), CT Scan / MRI Scan results (for Stroke and Benign Brain Tumour) and all Laboratory and Test results, etc and any relevant hospital reports that are available.

_____
Signature of Attending Doctor

Name & Qualification : _____

_____
Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy) : _____

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NRIC / Passport No : _____

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SECTION 1 : GENERAL INFORMATION

a Since when has the patient been seeing you for any condition? _____ (dd/mm/yyyy)

Please provide the Name and Address of the patient's regular General Practitioner:

_____

Please provide the Name and Address of the referring doctor and attach a copy of the referral letter:

_____

b When did patient first consult you for this illness? _____ (dd/mm/yyyy)

c Please state symptoms presented and the date symptoms first appeared as follows :

Symptoms Presented	Date symptoms first started (dd/mm/yyyy)	Duration of symptoms

d Please provide full and exact details of the diagnosis and its clinical basis.

_____

e What is the date of diagnosis? _____ (dd/mm/yyyy)

f What is the date when diagnosis was first made known to the patient? _____ (dd/mm/yyyy)

g Has the patient previously suffered from the condition described above or any related illness? ☐ Yes ☐ No

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

Illness	Date of First Diagnosis (dd/mm/yyyy)	Name and Address of Attending Doctor

h Is there anything in the patient's personal medical history or family history which would have increased the risk of the above illness? If yes, please give full details including the date of diagnosis and name & address of attending doctor. ☐ Yes ☐ No

_____

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

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

Illness	Date of First Diagnosis (dd/mm/yyyy)	Source of Information	Name and Address of Attending Doctor

j Please give details of the patient's past and present smoking habits, including the duration and number of cigarettes smoked per day.

_____

k Is the condition cause directly or indirectly by any misuse or abuse of drugs and/or alcohol? ☐ Yes ☐ No

If Yes, please provide details: _____

l Is the patient mentally incapacitated in accordance to the Mental Capacity Act 2008 (2020 Revised Edition)? ☐ Yes ☐ No

m What is the date of last consultation with you before completion of this Doctor's Statement? _____ (dd/mm/yyyy)

_____ Signature of Attending Doctor

Name & Qualification : _____

_____ Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy) : _____

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Name of Patient : _____
NRIC / Passport No : _____

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SECTION 2 : HEART ATTACK

a Please state the date where Heart Attack was first diagnosed _____ (dd/mm/yyyy)

b Was there a current history of chest pain? ☐ Yes ☐ No

c Where there any changes in the ECG indicative of a myocardial infarction? ☐ Yes ☐ No

d Was there any new regional wall motion abnormality? ☐ Yes ☐ No

e Was there a diagnostic elevation of cardiac enzymes CK-MB documented? ☐ Yes ☐ No

If **Yes**, please state Reading : _____ Date : _____ (dd/mm/yyyy)

f Was there a death of a portion of the heart muscle? ☐ Yes ☐ No

g Was there elevation of Troponin (T or I) documented? ☐ Yes ☐ No

If **Yes**, please state = Troponin Reading : _____ Date : _____ (dd/mm/yyyy)

h Was left ventricular ejection fraction (LVEF) taken 3 months or more after the event? ☐ Yes ☐ No

i If **Yes**, please state = LVEF % : _____ Date : _____ (dd/mm/yyyy)

j Date of return to normal activities : _____ (dd/mm/yyyy)

k What was the treatment/intervention rendered?

_____

SECTION 3 : CARDIAC PACEMAKER / DEFIBRILLATOR INSERTION

a Was pathway ablation therapy attempted? ☐ Yes ☐ No

b If **Yes**, please state the date of therapy : _____ (dd/mm/yyyy)

c If **No,** please state the reason why this is not done:

_____

d Was a permanent cardiac pacemaker inserted? ☐ Yes ☐ No

e If **Yes**, please state the date of insertion : _____ (dd/mm/yyyy)

f Was a permanent cardiac defibrillator inserted? ☐ Yes ☐ No

g If **Yes**, please state the date of insertion : _____ (dd/mm/yyyy)

h Was the insertion of cardiac pacemaker / defibrillator absolutely necessary? ☐ Yes ☐ No

i Was there any other means to treat the patient's cardiac arrhythmia? ☐ Yes ☐ No

j If **Yes,** please state the alternative means of treatment:

_____

k If **No**, please state the reason why the alternative means were not considered:

_____

SECTION 4 : PERICARDIAL DISEASE

_____ Signature of Attending Doctor

Name & Qualification : _____

_____ Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy) : _____

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a Please state the date where pericardial disease was first diagnosed

_____ (dd/mm/yyyy)

b If **Yes,** please state the nature of surgery performed (e.g. pericardectomy or other keyhole cardiac surgery) and date of surgery:

_____ _____ (dd/mm/yyyy)

SECTION 5 : CARDIOMYOPATHY

a Please state the date where Cardiomyopathy was first diagnosed

_____ (dd/mm/yyyy)

b Does the patient have any physical impairment which fulfills the New York Heart Association (NYHA) Classification of Cardiac Impairment? ☐ Yes ☐ No

c If **Yes,** please provide details of the physical impairment:

_____

d Please state the NYHA Class:

_____

e Is the patient's condition of Cardiomyopathy related to alcohol misuse? ☐ Yes ☐ No

f If **Yes**, please provide details of alcohol consumption, including frequency, amount, duration and types of alcohol :

_____

SECTION 6 : OPEN CHEST HEART VALVE SURGERY

a What is the date of onset of the heart valve defects?

_____ (dd/mm/yyyy)

b Was surgery performed to repair or replace the heart valve abnormality? ☐ Yes ☐ No

c If Yes, please state the surgical procedure used to correct the valvular problem (i.e. open heart surgery, percutaneous intravascular balloon valvuloplasty with OR without thoracotomy etc)

_____

d What was the date of the surgery?

_____ (dd/mm/yyyy)

e Was there any deployment of :

(i) new valve ☐ Yes ☐ No

(ii) percutaneous device ☐ Yes ☐ No

(iii) prosthesis ☐ Yes ☐ No

f Has the patient suffered or is suffering from any related illnesses e.g. hypertension, vascular disease etc

_____

SECTION 7 : CORONARY ARTERY BY-PASS SURGERY / ANGIOPLASTY & OTHER INVASIVE TREATMENT FOR CORONARY ARTERY / OTHER SERIOUS CORONARY ARTERY DISEASE

_____ Signature of Attending Doctor

_____ Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____

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Name of Patient : _____
NRIC / Passport No : _____

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a Please describe the full and exact diagnosis of the heart condition leading to surgery:

b Please specify the coronary arteries involved and the percentage of stenosis as shown below:

Coronary Artery	Stenosis	Percentage of Stenosis	Coronary Artery By-Pass: Graft inserted	Angioplasty: Stent inserted
Left: Main Stem	Yes / No		☐	☐
Left: Anterior descending Artery	Yes / No		☐	☐
Left: Circumflex Artery	Yes / No		☐	☐
Right: Coronary Artery	Yes / No		☐	☐

c Please state the type of surgery performed [i.e. Angioplasty, Coronary Artery By-Pass Surgery, 'Keyhole' surgery, Atherectomy, Transmycardial Laser Revascularisation, Enhanced External Counterpulsation or Minimally Invasive Direct Coronary Artery Bypass (MIDCAB)

d If a Coronary Artery By-Pass surgery was performed:

(i) was open-chest surgery performed? ☐ Yes ☐ No

(ii) what is the date of the surgery? _____ (dd/mm/yyyy)

e If an Angioplasty was performed, what is the date of the surgery? _____ (dd/mm/yyyy)

f Please provide the name of surgeon who perform the surgery and the name & address of hospital where the surgery was performed

g Has the patient previously suffered from the above illnesses or any other cardiovascular diseases?

h Please give details of the patient's medical history which would have increased the risk of coronary artery disease (eg Hypertension, Hyperlipidaemia, Diabetes)

SECTION 8 : OPEN CHEST SURGERY TO AORTA

a On what date did the patient first become aware of the condition necessitating surgery? _____ (dd/mm/yyyy)

b What was the type of surgery performed?

c When was the surgery performed? _____ (dd/mm/yyyy)

d Was excision and surgical replacement of the diseased aorta with a graft performed? ☐ Yes ☐ No

e Was the surgery performed using minimally invasive or intra arterial techniques? ☐ Yes ☐ No

f Was there enlargement of the aorta? ☐ Yes ☐ No

If **Yes**, please state the diameter of enlargement in millimetres:

g Has the patient suffered or is suffering from any related illnesses e.g. hypertension, angina, vascular disease, endocarditis etc

Signature of Attending Doctor

Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____

(2025.10)

Name of Patient : _____
NRIC / Passport No : _____

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SECTION 9 : STROKE WITH PERMANENT NEUROLOGICAL DEFICIT / BRAIN ANEURYSM / CAROTID ARTERY SURGERY

a Please describe the episode:

(i) Date of episode _____ (dd/mm/yyyy)

(ii) Nature of the episode and duration of the acute symptoms:

_____

(iii) Is the patient able to resume normal activities? ☐ Yes ☐ No
If **Yes**, please state the date he/she has returned OR is expected to return to normal activities:

(iv) Please state the patient's current physical and mental limitations:

Date of Assessment	Neurological Limitation	Is this likely to be permanent?

(v) If a further assessment is required to assess if the neurological limitations are permanent, please indicate the proposed date of assessment: _____ (dd/mm/yyyy)

b (i) Was there any evidence of neurological deficit 6 weeks after the date of stroke diagnosis? ☐ Yes ☐ No

Was there any evidence of neurological damage 6 weeks after the date of stroke diagnosis? ☐ Yes ☐ No

If **Yes,** please provide details:

_____

(ii) Has there been an infarction of brain tissue, haemorrhage or embolisation from an extracranial source? ☐ Yes ☐ No

(iii) Are the investigations or findings consistent with the diagnosis of a NEW stroke? ☐ Yes ☐ No

If **Yes,** please provide details:

_____

c (i) Is this a Transient Ischaemic Attack? ☐ Yes ☐ No

(ii) Is the brain damage due to an accident or injury, infection, vasculitis or inflammatory disease? ☐ Yes ☐ No

(iii) Is the illness a vascular disease affecting the eye or optic nerve? ☐ Yes ☐ No

(iv) Is the current condition a result of ischaemic disorders of the vestibular system? ☐ Yes ☐ No

d Was an arteriogram carried out? If **Yes**, please state the date of arteriogram: _____ (dd/mm/yyyy)

e (i) Was surgery carried out to correct intracranial aneurysm or arterio-venous malformation? If **Yes,** please state the date of surgery: _____ (dd/mm/yyyy)

(ii) Was surgery done via craniotomy? ☐ Yes ☐ No
If No, please state the type of surgery performed:

_____

f Was there surgical shunt insertion from the ventricles of the brain to relieve raised pressure in the cerebrospinal fluid? ☐ Yes ☐ No
If **Yes**, please state the date of insertion: _____ (dd/mm/yyyy)

g (i) Was there narrowing of the carotid artery? ☐ Yes ☐ No
If **Yes,** please state the percentage of narrowing : _____ %

(ii) Was Endarterectomy of the carotid artery absolutely necessary? ☐ Yes ☐ No
If **Yes**, please state the actual date where Endarterectomy was performed: _____ (dd/mm/yyyy)

_____ _____

Signature of Attending Doctor | Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____

(2025.10)

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Name of Patient : _____
NRIC / Passport No : _____

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SECTION 10 : MAJOR CANCERS / CARCINOMA IN SITU / BREAST RECONSTRUCTIVE SURGERY AFTER MASTECTOMY

a Please describe the extent of the disease:

(i) What is the histological diagnosis of the disease?

(ii) What is the staging of the Tumour?

(iii) Is the tumour in the presence of HIV infection? ☐ Yes ☐ No

If Yes, please state diagnosis date of HIV infection: _____ (dd/mm/yyyy)

b (i) Is the disease completely localized? ☐ Yes ☐ No

(ii) Was there invasion of adjacent tissues? ☐ Yes ☐ No

(iii) Were regional lymph nodes involved? ☐ Yes ☐ No

(iv) Were there distant metastases? ☐ Yes ☐ No

c To be completed ONLY if diagnosis is pre-malignant or non-invasive, skin cancer, prostate cancer, thyroid and bladder cancer or chronic lymphocytic leukaemia or gastro-intestinal stromal tumour:

(i) Is the condition carcinoma-in situ? ☐ Yes ☐ No

(ii) Is the condition Cervical Dysplasia CIN 1, CIN 2 or CIN 3 (severe dysplasia without carcinoma-in situ)? ☐ Yes ☐ No

(iii) Is the condition Hyperkeratoses, basal cell and squamous skin cancers? ☐ Yes ☐ No

(iv) Is the condition melanoma of less than 1.5mm Breslow thickness or less than Clark Level 3? ☐ Yes ☐ No

If **Yes,** please provide full details of size, thickness (Breslow thickness) and depth of invasion (Clark Level):

(v) Is the condition Chronic Lymphocytic Leukaemia classified as lesser than RAI Stage 3? ☐ Yes ☐ No

(vi) Is the condition Prostate cancer described as TNM classification T1 (i.e. T1a, T1b, T1c) or equivalent or lesser? ☐ Yes ☐ No

(vii) Is the condition Papillary micro-carcinoma of the Thyroid of less than 1cm size in diameter? ☐ Yes ☐ No

(viii) Is the condition Papillary micro-carcinoma of the Bladder? ☐ Yes ☐ No

(ix) For Gastro-Intestinal Stromal tumours (GIST), is the tumour classified as T1N0M0 or below? ☐ Yes ☐ No

d Please provide details of treatment administered (e.g. surgery, chemotherapy, radiotherapy etc)

e What is the nature of the surgery performed (e.g mastectomy, prostatectomy, gastrectomy)? Please provide the operation report.
Please specify if there was full or partial resection. For mastectomy, please indicate how many quadrants of the tissue of a breast was surgically removed due to the carcinoma-in-situ or a malignant condition.

(i) When was the surgery performed? _____ (dd/mm/yyyy)

(ii) If a surgery is planned, please indicate the nature of the surgery and the planned date. _____ (dd/mm/yyyy)

g Has the patient ever suffered from cancer, malignant, pre-malignant or other related conditions or risk factors?
If **Yes**, please provide full details with dates of consultation and the resulting diagnosis:

Signature of Attending Doctor

Name & Qualification : _____

Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy) : _____

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SECTION 11 : ALZHEIMER'S DISEASE / SEVERE DEMENTIA

a Please describe the extent of the disease:

(i) Is there evidence of deterioration or loss of intellectual capacity? ☐ Yes ☐ No

(ii) Is there abnormal behaviour resulting in significant reduction in mental and social functioning requiring the continuous supervision of patient? ☐ Yes ☐ No

If **Yes,** please describe the behaviour:

_____

(iii) Was there permanent clinical loss of the ability to do the following:

- Remember ☐ Yes ☐ No
- Reason ☐ Yes ☐ No
- Perceive, understand, express and give effect to ideas ☐ Yes ☐ No

b Did the deterioration or loss of intellectual capacity arise from neurosis, psychiatric illnesses or alcohol related brain damage?
If **Yes,** please provide us with the details :

_____

c Was there evidence of cognitive impairment for at least 6 months? If Yes, please state the type of cognitive impairments and its duration:

_____

d Please provide details of any investigations performed including the type of Alzheimer's test (e.g. Mini-mental exam) and its score

_____

e (i) Is the current condition arises from non-organic diseases such as neurosis and psychiatric illnesses? ☐ Yes ☐ No

(ii) Is the current condition a case of drug or alcohol related brain damage ☐ Yes ☐ No

f Was there any memory impairment in the following cognitive areas? ☐ Yes ☐ No
If **Yes**, please tick the box and state the exact date of onset:

Date of Onset

(i) ☐ Aphasia _____ (dd/mm/yyyy)

(ii) ☐ Apraxia _____ (dd/mm/yyyy)

(iii) ☐ Agnosia _____ (dd/mm/yyyy)

(iv) ☐ Disturbance in executive functioning _____ (dd/mm/yyyy)

Please provide the date of last assessment : _____ (dd/mm/yyyy)

g Is the patient currently placed on disease modifying treatment and under your continuous care? ☐ Yes ☐ No

If **Yes,** please provide us with the treatment regime and state the frequency of consultation(s) with your clinic :

_____

_____ _____

Signature of Attending Doctor | Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____ Date (dd/mm/yyyy) : _____

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SECTION 12 : IRREVERSIBLE APLASTIC ANAEMIA

a Please provide full details of tests and results which have been performed to establish the diagnosis of Aplastic Anaemia

_____

_____

b What is the cause of patient's aplastic anaemia?

(i) Acute reversible bone marrow failure ☐ Yes ☐ No

(ii) Chronic persistent bone marrow failure ☐ Yes ☐ No

c Was any of the following present? If yes, please provide us with the relevant laboratory results.

(i) Anaemia ☐ Yes ☐ No

(ii) Neutropenia ☐ Yes ☐ No

(iii) Thrombocytopenia ☐ Yes ☐ No

d What is the nature of treatment?

(i) Blood product transfusions ☐ Yes ☐ No

(ii) Marrow stimulating agents ☐ Yes ☐ No

(iii) Immunosuppressive agents ☐ Yes ☐ No

(iv) Bone marrow transplantation ☐ Yes ☐ No

e Is the current condition in any way attributable to HIV infection or AIDS? ☐ Yes ☐ No

If **Yes,** please provide us with the details

_____

SECTION 13 : SEVERE BACTERIAL MENINGITIS

a Was the diagnosis confirmed by the presence of bacterial infection in cerebrospinal fluid by lumbar puncture? ☐ Yes ☐ No

b Has the patient returned to normal activities? ☐ Yes ☐ No

If **Yes,** please provide the date.

_____
(dd/mm/yyyy)

c What are the patient's present limitations, physical and mental?

_____

d Were there any neurological deficit which has lasted for at least 6 weeks? ☐ Yes ☐ No

Are these neurological deficits likely to be permanent? ☐ Yes ☐ No
If **Yes**, please provide details of the deficits.

_____

e Was the condition present due to HIV / AIDS infections? ☐ Yes ☐ No

_____ _____

Signature of Attending Doctor

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SECTION 14 : BENIGN BRAIN TUMOUR

a Has the tumour caused an increase in the intracranial pressure? ☐ Yes ☐ No

If **Yes**, please provide the detailed location of the tumour.

b Is the tumour life threatening? ☐ Yes ☐ No

c Has the tumour caused damage to the brain? ☐ Yes ☐ No
If yes, please provide details.

d Has the patient undergone surgical removal? ☐ Yes ☐ No
If **Yes**, please state the type and exact date the surgery was performed

(i) ☐ Transphenoidal _____ (dd/mm/yyyy)

(ii) ☐ Transnasal Hypophysectomy _____ (dd/mm/yyyy)

(iii) ☐ Open craniotomy _____ (dd/mm/yyyy)

If **No**, please provide the planned date for surgical removal. _____ (dd/mm/yyyy)

e If the surgical removal is not performed, has the tumour caused permanent neurological deficit? ☐ Yes ☐ No
If **Yes**, please provide details of the deficits.

f Is the patient's condition a cyst, granuloma, vascular malformation or haematoma? ☐ Yes ☐ No

g Is the patient's tumour in the pituitary gland or spinal cord? ☐ Yes ☐ No

h Is the tumour confirmed by imaging studies such as CT scan or MRI? ☐ Yes ☐ No

SECTION 15 : BLINDNESS (IRREVERSIBLE LOSS OF SIGHT) / OPTIC NERVE ATROPHY

a What was the date of onset? _____ (dd/mm/yyyy)

b With the use of visual aids, what is the current visual acuity of both eyes, using the Snellen eye chart?

Left eye: _____ Right eye: _____

c What forms of treatment were rendered?

d Is the current blindness in both eyes permanent and irreversible? ☐ Yes ☐ No

e Will further surgery improve his / her sight? ☐ Yes ☐ No
If **Yes**, what kind of surgery will be necessary and what is the tentative date of surgery?

f Is the condition resulting from alcohol or drug misuse? ☐ Yes ☐ No
If **Yes**, please provide us with the details.

Signature of Attending Doctor

Name & Qualification : _____

Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy) : _____

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SECTION 16 : COMA / SEVERE EPILEPSY

a What was the date of onset?

_____ (dd/mm/yyyy)

b How was the diagnosis established? Please include a copy of diagnostic investigation reports (eg electroencephalography (EEG), Magnetic Resonance Imaging (MRI), Position Emission Tomography (PET) etc).

_____

c Was there any reaction or response to external stimuli or internal needs persisting continuously with the use of a life support system for:

(i) at least 48 hours? ☐ Yes ☐ No

(ii) at least 72 hours? ☐ Yes ☐ No

(iii) at least 96 hours? ☐ Yes ☐ No

d Was there brain damage resulting in permanent neurological deficit? ☐ Yes ☐ No

e Has the sequelae lasted more than 30 days from the onset of the coma? ☐ Yes ☐ No

f Has the patient experienced recurrent unprovoked tonic-clonic or grand mal seizures and be known to be resistant to optimal therapy as confirmed by drug-serum level testing? ☐ Yes ☐ No

If **Yes**, what is the frequency of attack per week?

_____ attacks per week

g Is the patient taking prescribed anti-epileptic (anti-convulsant) medications? ☐ Yes ☐ No
If **Yes**, please state the type(s) of medication and period he has been on such medication:

_____

h Would you consider the patient to be on optimal drug therapy? ☐ Yes ☐ No
If **Yes**, please state the type(s) and recommended duration of such therapy:

_____

i Is the condition resulting from alcohol, drug misuse or medically induced coma? ☐ Yes ☐ No
If **Yes**, please provide us with the details.

_____

SECTION 17 : DEAFNESS (IRREVERSIBLE LOSS OF HEARING)

a What was the date of onset?

_____ (dd/mm/yyyy)

b Was the diagnosis confirmed by an audiometric and sound-threshold? ☐ Yes ☐ No

c Is the loss of hearing considered irreversible? ☐ Yes ☐ No

d Is there a loss in all frequencies of hearing of:

(i) at least 60 decibels ☐ Yes ☐ No

(ii) at least 80 decibles ☐ Yes ☐ No

e Has the patient undergone surgery to:

(i) drain cavernous sinus thrombosis ☐ Yes ☐ No

(ii) insert implant due to permanent damage of cochlea or auditory nerve ☐ Yes ☐ No

If **Yes**, please state the actual date of surgery:

_____ (dd/mm/yyyy)

f Could the patient's hearing be restored fully or partially by medical treatment, hearing aid and/or surgical procedures? Please elaborate:

_____

_____ Signature of Attending Doctor

_____ Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____

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SECTION 18 : SEVERE ENCEPHALITIS

a Was the condition caused by viral infection? ☐ Yes ☐ No

b Was the patient hospitalised? ☐ Yes ☐ No
If **Yes,** please provide the exact dates and duration of admission:

c Has the patient returned to normal activities? ☐ Yes ☐ No
If **Yes,** please provide the date.

_____ (dd/mm/yyyy)

d What are the patient's present limitations, physical and mental?

e Was there any significant and serious permanent neurological deficit? ☐ Yes ☐ No
If **Yes**, please provide details of the deficit.

f Are the permanent neurological deficits documented for at least 6 weeks? ☐ Yes ☐ No
If **Yes,** please provide details.

g Was the condition present due to HIV / AIDS infections? ☐ Yes ☐ No

SECTION 19 : END STAGE LIVER FAILURE / LIVER DISEASE

a Was there end stage liver failure? ☐ Yes ☐ No
If **Yes,** please state the date of diagnosis

_____ (dd/mm/yyyy)

b Was there evidence of permanent jaundice? ☐ Yes ☐ No

c Was there evidence of ascites? ☐ Yes ☐ No

d Was there evidence of hepatic encephalopathy? ☐ Yes ☐ No

e Was there partial hepatectomy of at least one entire lobe of the liver? ☐ Yes ☐ No
If **Yes,** please state the exact date of surgery

_____ (dd/mm/yyyy)

f Was there cirrhosis of the liver? ☐ Yes ☐ No
If **Yes,** please provide us with the HAI-Knodell Scores together with the liver biopsy result

g. What was the cause of the liver failure?

h Was the liver disease secondary to alcohol or drug abuse? ☐ Yes ☐ No
If **Yes**, please provide details:

i What is the current condition of the patient and the prognosis?

Signature of Attending Doctor

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SECTION 20 : END STAGE LUNG DISEASE / SEVERE ASTHMA

a (i) Has the patient's lung disease reached end-stage? ☐ Yes ☐ No
If yes, please state the exact date:

_____ (dd/mm/yyyy)

(ii) What is the FEV1 test result of the patient?

(iii) Is the patient undergoing extensive and permanent oxygen therapy for hypoxemia? ☐ Yes ☐ No

(iv) What is the Arterial blood gas analyses (PaO_2) of the patient?

b (i) Is there evidence of acute attack of severe asthma with persistent status of asthmaticus? ☐ Yes ☐ No
If yes, please state the exact date and details:

_____ (dd/mm/yyyy)

(ii) Was the patient hospitalised and required assisted ventilation with a mechanical ventilator for a continuous period of at least 4 hours? ☐ Yes ☐ No
If **Yes**, please explain:

c Please provide us with the first and subsequent dates where the patient consulted you for pulmonary emboli:

Date	Sign and symptoms	Treatment Provided	Patient's response to treatment	Name and Address of Attending Doctor

d Has the patient undergone surgery to:
(i) Insert vena cava filter due to documented proof of recurrent pulmonary emboli ☐ Yes ☐ No
(ii) Completely remover of one lung as a result of an accident or an illness ☐ Yes ☐ No
If **Yes**, please state the actual date of surgery:

_____ (dd/mm/yyyy)

SECTION 21 : POLIOMYELITIS

a i. What was the cause of the disease?

ii. What is the current condition of the patient and what is the prognosis?

iii. Was there paralysis of the limb muscles or respiratory muscles for at least 3 months? ☐ Yes ☐ No

Signature of Attending Doctor

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SECTION 22 : FULMINANT HEPATITIS / BILIARY TRACT DISEASE

a	(i)	Please provide full and exact details of the diagnosis including the viru(s) involved.		
	(ii)	What is the approximate date of onset? _____ (dd/mm/yyyy)		
	(iii)	Is there a rapidly decreasing liver size?	☐ Yes	☐ No
	(iv)	Is there a submassive to massive necrosis of the liver?	☐ Yes	☐ No
	(v)	Is there a rapidly deterioration of liver function?	☐ Yes	☐ No
	(vi)	Is there deepening jaundice?	☐ Yes	☐ No
	(vii)	is there hepatic encephalopathy?	☐ Yes	☐ No
b	(i)	Has the patient undergone biliary tract reconstruction surgery involving choledochoenterostomy (choledochojejunostomy or choledochoduodenostomy) for the treatment of biliary tract disease, including biliary atresia? If **Yes**, please state the actual date of surgery: _____ (dd/mm/yyyy)	☐ Yes	☐ No
	(ii)	Is the biliary tract disease NOT amendable by other surgical or endoscopic measures?	☐ Yes	☐ No
	(iii)	Is the procedure considered the most appropriate treatment?	☐ Yes	☐ No
	(iv)	Is patient's current condition a consequence of gall stone disease or cholangitis?	☐ Yes	☐ No
c	(i)	Is patient's condition of chronic primary sclerosing cholangitis confirmed by cholangiogram?	☐ Yes	☐ No
	(ii)	Is there progressive obliteration of the bile ducts?	☐ Yes	☐ No
	(iii)	Is there permanent jaundice?	☐ Yes	☐ No
	(iv)	Is there a need for immunosuppressive treatment, drug therapy for intractable pruritis or ballon dilation or stenting of the bile ducts? If **Yes**, please provide the details: _____	☐ Yes	☐ No
	(v)	Is patient's current condition a consequence of biliary surgery, gall stone disease, infection, inflammatory bowel disease or other secondary precipitants? If **Yes**, please provide the details: _____	☐ Yes	☐ No
d	What is the current condition of the patient and what is the prognosis? _____			

Signature of Attending Doctor

Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____

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NRIC / Passport No : _____

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SECTION 23 : HIV DUE TO BLOOD TRANSFUSION & OCCUPATIONALLY ACQUIRED HIV

a (i) Was the infection due to :

- blood transfusion? ☐ Yes ☐ No
- organ transplant? ☐ Yes ☐ No
- physical or sexual assault? ☐ Yes ☐ No

(ii) Was the blood transfusion or organ transplant medically necessary or given as part of medical treatment? ☐ Yes ☐ No

(iii) Did the incident of infection occur in Singapore? ☐ Yes ☐ No

If **Yes**, please provide the exact date and details:

_____ _____ (dd/mm/yyyy)

(iv) Was the infection resulted from any other means including sexual activity and the use of intravenous drugs? If **Yes**, please state the likely cause: ☐ Yes ☐ No

_____

(v) Was the incident of infection established to involve a definite source of the HIV infected fluids? ☐ Yes ☐ No

(vi) Was the incident of infection reported to the appropriate authority? ☐ Yes ☐ No

(vii) Is the Institution where the blood transfusion or organ transplant was performed able to trace the origin of the HIV tainted blood? ☐ Yes ☐ No

b. Is the patient suffering from Thalassaemia Major or Haemophilia? ☐ Yes ☐ No

c. Is the occupation of the patient a medical practitioner, houseman, medical student, state registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in medical centre or clinic in Singapore? ☐ Yes ☐ No
If **Yes,** please state the actual occupation and name of employer or Institution:

_____

d (i) Was there an accident whilst the patient was carrying out the normal professional duties of his occupation in Singapore? ☐ Yes ☐ No
If **Yes,** please state the date of accident:

_____ (dd/mm/yyyy)

(ii) Was the accident involved a definite source of the HIV infected fluids? ☐ Yes ☐ No

e (i) Was an HIV antibody test done before the incident of infection? ☐ Yes ☐ No
If **Yes,** what was the result?

_____

(ii) Was an HIV antibody test done after the incident of infection? ☐ Yes ☐ No
If **Yes,** what was the result?

_____

_____ _____
Signature of Attending Doctor Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____ Date (dd/mm/yyyy) : _____

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NRIC / Passport No : _____

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SECTION 24 : END STAGE KIDNEY FAILURE / CHRONIC KIDNEY DISEASE

a	(i)	Has the patient's renal disease reached end-stage?	☐ Yes	☐ No
	(ii)	Is there chronic renal failure of both kidneys?	☐ Yes	☐ No
	(iii)	Is the renal failure reversible?	☐ Yes	☐ No
b	(i)	Is the patient undergoing regular peritoneal dialysis or haemodialysis?	☐ Yes	☐ No
		If **Yes,** what was the date of commencement? _____ (dd/mm/yyyy)		
		If **No**, what is the planned date of commencement? _____ (dd/mm/yyyy)		
	(ii)	Has renal transplantation been performed?	☐ Yes	☐ No
		If **Yes**, when was it done? _____ (dd/mm/yyyy)		
c	(i)	Was the patient a recipient of the renal transplant?	☐ Yes	☐ No
	(ii)	Is the renal dialysis / transplantation required as a life-saving procedure?	☐ Yes	☐ No
	(iii)	Was there decreased renal function of at least eGFR less than 15ml/min/1.73m2 body surface? If **Yes**, did it persist for a period of at least 6 months and what are the details:	☐ Yes	☐ No

_____

SECTION 25 : IRREVERSIBLE LOSS OF SPEECH / PERMANENT TRACHEOSTOMY

a	(i)	What is the date of onset? _____ (dd/mm/yyyy)		
	(ii)	Is the loss of speech considered total and irrecoverable?	☐ Yes	☐ No
	(iii)	Has the inability to speak established for a continuous period of 12 months?	☐ Yes	☐ No
	(iv)	Were there any associated neurological or psychiatric conditions contributing to the patient's loss of speech? If **Yes,** please provide details.	☐ Yes	☐ No

_____

b What was the cause of the loss of speech?

_____

c	(i)	Has tracheostomy been performed? If **Yes**, what is purpose of such treatment and when was it done? _____ (dd/mm/yyyy)	☐ Yes	☐ No
	(ii)	Was tracheostomy performed for treatment of lung or airway disease or as a ventilator support measure following major trauma or burns? If **Yes**, please provide the details:	☐ Yes	☐ No
	(iii)	Was the patient under the care of medical specialist in a designated intensive care unit (ICU)? If **Yes**, how many days was he/she warded in ICU:	☐ Yes	☐ No
	(iv)	Is the tracheostomy required to remain in place and functional for a period of at least 3 months?	☐ Yes	☐ No

_____ _____

Signature of Attending Doctor

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NRIC / Passport No : _____

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SECTION 26 : MAJOR / SEVERE BURNS

a (i) What is the date of onset?

_____
(dd/mm/yyyy)

(ii) Please state the areas affected, the percentage of surface area and the degree of burns in each affected area:

Area Affected	Percentage of surface area	Degree of burns

(iii) Were there Second Degree (partial thickness of the skin) burns covering at least 20% of the surface of the patient's body? ☐ Yes ☐ No

(iv) Were there Third Degree (full thickness of the skin) burns covering at least 20% of the surface of the patient's body? ☐ Yes ☐ No

(v) Were there Third Degree (full thickness of the skin) burns covering at least 50% of patient's face or head? ☐ Yes ☐ No

b (i) Where and how did the accident happen resulting in the major burns?

_____

(ii) Are the burns self-inflicted? ☐ Yes ☐ No
If **Yes**, please provide details.

_____

c (i) Is surgical debridement under general anaesthetic required? ☐ Yes ☐ No
If **Yes**, when will it be performed?

_____
(dd/mm/yyyy)

(ii) Is skin grafting required? ☐ Yes ☐ No
If **Yes**, when will it be performed?

_____
(dd/mm/yyyy)

SECTION 27 : MAJOR ORGAN / BONE MARROW TRANSPLANT

a (i) Which of the organ is involved?

_____

(ii) What is the exact date of transplant?

_____
(dd/mm/yyyy)

(iii) What is the prognosis?

_____

(iv) Was the transplant resulted from an irreversible end stage failure of the relevant organ? ☐ Yes ☐ No

b (i) For bone marrow transplant, is the receipt of transplant from human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation? ☐ Yes ☐ No

(ii) For small bowel transplant, is there receipt of at least one meter of small bowel resulting from intestinal failure? ☐ Yes ☐ No

(iii) For corneal transplant, is there receipt of a whole cornea due to irreversible scarring with resulting reduced visual acuity which cannot be corrected with other methods? ☐ Yes ☐ No

_____ _____
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SECTION 28 : MOTOR NEURONE DISEASE / PERIPHERAL NEUROPATHY

a (i) Is there progressive degeneration of:
- corticospinal tracts; ☐ Yes ☐ No
- anterior horn cells; ☐ Yes ☐ No
- bulbar efferent neurones which include spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis and primary lateral sclerosis ☐ Yes ☐ No

If answer to any of the above is **Yes,** please provide details:

_____

(ii) Please provide details of the extent of neurological deficits.

_____

(iii) Are the neurological deficits likely to be permanent? ☐ Yes ☐ No

b (i) For peripheral neuropathy, is it arising from anterior horn cells resulting in significant motor weakness, fasciculation and muscle wasting? ☐ Yes ☐ No

(ii) Is the diagnosis evident in nerve conduction studies? ☐ Yes ☐ No

(iii) Is there a permanent need for the use of walking aids or wheelchair? ☐ Yes ☐ No

c (i) Is the current condition arising from diabetic neuropathy? ☐ Yes ☐ No

(ii) Is the neuropathy arising from excessive alcohol consumption? ☐ Yes ☐ No

SECTION 29 : MULTIPLE SCLEROSIS

a i. Is there a history of repeated relapse and remission or a steady progressive disability? ☐ Yes ☐ No

ii. Are there lesions producing well-defined neurological deficits involving the optic nerves, brain stem and spinal cord which occurred over a continuous period of :
- at least 3 months? ☐ Yes ☐ No
- at least 6 months? ☐ Yes ☐ No

iii. Are there signs and symptoms of multiple lesions? ☐ Yes ☐ No

iv. Was the neurological damages caused by SLE or HIV / AIDS? ☐ Yes ☐ No
If **Yes,** what was the cause?

_____

b Is there a well documented history of exacerbations and remissions of neurological signs? ☐ Yes ☐ No
If **Yes,** please provide the details, including dates of each episode:

_____

c Has the patient returned to normal activities? ☐ Yes ☐ No
If **Yes,** please provide the date.

_____
(dd/mm/yyyy)

d What are the patient's present limitations, physical and mental?

_____

_____ _____
Signature of Attending Doctor Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____ Date (dd/mm/yyyy) : _____

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SECTION 30 : MUSCULAR DYSTROPHY / SPINAL CORD DISEASE

a (i) Is there any evidence of sensory disturbance, abnormal cerebrospinal fluid, or diminished tendon reflex? If **Yes,** please describe the findings: ☐ Yes ☐ No

(ii) Which are the muscles involved?

b (i) Was the diagnosis confirmed by an electromyogram? ☐ Yes ☐ No

(ii) Was the diagnosis confirmed by muscle biopsy? ☐ Yes ☐ No

c Is the patient able to perform (whether aided* or unaided) for a continuous period of at least 6 months the followings:

(i) Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means ☐ Yes ☐ No

(ii) Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances ☐ Yes ☐ No

(iii) Ability to move from a bed to an upright chair or wheelchair and vice versa ☐ Yes ☐ No

(iv) Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene ☐ Yes ☐ No

(v) Ability to move indoors from room to room on level surfaces ☐ Yes ☐ No

(vi) Ability to feed oneself once food has been prepared and made available ☐ Yes ☐ No

* Aided shall mean with the aid of special equipment, device and / or apparatus and not pertaining to human aid

d (i) For bowel and bladder dysfunction, is there permanent dysfunction requiring permanent regular self catheterisation or permanent urinary conduit? ☐ Yes ☐ No

(ii) Has the bowel and bladder dysfunction lasted for at least 6 months? ☐ Yes ☐ No

If **Yes,** please provide the exact date of onset:

_____
(dd/mm/yyyy)

SECTION 31 : PARALYSIS (IRREVERSIBLE LOSS OF USE OF LIMBS)

a i. When was the date of onset?

_____
(dd/mm/yyyy)

ii. Please state the number and limbs involved?

b Is there total and irreversible loss of use of at least 1 entire limb? ☐ Yes ☐ No

c Was the paralysis or loss of use of 1 limb due to illness or injury? ☐ Yes ☐ No
Please provide details on the cause:

d Was the paralysis or loss of use of 1 limb caused by self-inflicted injuries? ☐ Yes ☐ No
If **Yes**, please provide details:

Signature of Attending Doctor

Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____

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SECTION 32 : IDIOPATHIC PARKINSON'S DISEASE

a (i) What is the cause of the disease?

_____

_____

b (i) Can the condition be controlled with medication? ☐ Yes ☐ No

(ii) If **Yes**, please provide details and exact date where medication was commenced:

_____

_____

(iii) Are there signs of progressive impairment? ☐ Yes ☐ No
If **Yes,** please provide details:

_____

_____

(iv) Did Parkinson's Disease result from treatment for any other illness, or is it associated with any other disease e.g. Wilson's Disease or Huntington's Chorea? ☐ Yes ☐ No
If **Yes,** please provide details:

_____

_____

c Is the patient able to perform (whether aided* or unaided) for a continuous period of at least 6 months the followings:

(i) Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means ☐ Yes ☐ No

(ii) Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances ☐ Yes ☐ No

(iii) Ability to move from a bed to an upright chair or wheelchair and vice versa ☐ Yes ☐ No

(iv) Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene ☐ Yes ☐ No

(v) Ability to move indoors from room to room on level surfaces ☐ Yes ☐ No

(vi) Ability to feed oneself once food has been prepared and made available ☐ Yes ☐ No

* Aided shall mean with the aid of special equipment, device and / or apparatus and not pertaining to human aid

d (i) Is the Parkinsonism due to:
- drug induced cause ☐ Yes ☐ No
- toxic cause ☐ Yes ☐ No

_____ _____

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SECTION 33 : PRIMARY PULMONARY HYPERTENSION

a	(i)	Was there a dyspnoea and fatigue?	☐ Yes ☐ No
	(ii)	Is the pulmonary hypertension due to primary cause?	☐ Yes ☐ No
	(iii)	Is the pulmonary hypertension due to secondary cause?	☐ Yes ☐ No
	(iv)	Is there presence of right ventricular hypertrophy, dilation and signs of right heart failure and decompensation?	☐ Yes ☐ No
	(v)	Was cardiac catherterization carried out to establish the pulmonary hypertension?	☐ Yes ☐ No
b		Was the patient able to engage in any physical activity without discomfort?	☐ Yes ☐ No
c		Are the symptoms present even at rest?	☐ Yes ☐ No
d		Was there permanent physical impairment which fulfills the the NYHA classification of cardiac impairment?	☐ Yes ☐ No
		If **Yes**, please state the class of impairment:	NYHA Class : I / II / III / IV

SECTION 34 : SYSTEMIC LUPUS ERYTHEMATOSUS WITH LUPUS NEPHRITIS

a	(i)	Does patient's current condition requires systemic immunosuppressive therapy due to involvement of multiple organ?	☐ Yes ☐ No
		If **Yes**, please state the exact commencement date of the therapy :	_____ (dd/mm/yyyy)
	(ii)	Are the following internal organs involved:	
		▪ kidneys	☐ Yes ☐ No
		▪ brain	☐ Yes ☐ No
		▪ heart or pericardium	☐ Yes ☐ No
		▪ lungs or pleura	☐ Yes ☐ No
		▪ joints in the presence of polyarticular inflammatory arthritis	☐ Yes ☐ No
b	(i)	Was renal biopsy performed:	☐ Yes ☐ No
		If **Yes**, please state the exact date biopsy was done :	_____ (dd/mm/yyyy)
	(ii)	Are both kidneys involved :	☐ Yes ☐ No
		If **Yes**, please state the class of Lupus Nephritis in accordance with WHO classification :	Lupus Nephritis Class : I / II / III / IV
c	(i)	Were there discoid lupus and or those forms with haematological involvement? If Yes, please provide details:	☐ Yes ☐ No

_____

_____

_____ _____

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SECTION 35 : DIABETIC COMPLICATIONS

a (i) What is the cause of gangrene?

_____

b (i) For diabetic retinopathy, does patient require to undergo laser treatment? ☐ Yes ☐ No

(ii) Was Fluorescent Fundus Angiography performed? ☐ Yes ☐ No

If **Yes**, please state the exact date it was done :

_____ (dd/mm/yyyy)

(iii) Is patient's vision measured at 6/18 or worse in the better eye using a Snellen eye chart? ☐ Yes ☐ No

(iv) If **Yes**, please state the actual reading of the better eye and date the measurement was done:
Reading of better eye :

_____ (dd/mm/yyyy)

_____

c (i) For diabetic nephropathy, is there evidence of eGFR at less than 30 ml/min or 1.73 m^2? ☐ Yes ☐ No

(ii) Is there ongoing proteinuria greater than 300mg/24 hours? ☐ Yes ☐ No

d (i) Was there actual undergoing of foot / toe / hand / finger amputation? ☐ Yes ☐ No

(ii) If **Yes**, please state the exact date and body part that was amputated :

Amputation of : foot / toe / hand / finger (please circle the affected area)

_____ (dd/mm/yyyy)

SECTION 36 : OSTEOPOROSIS

a (i) Was there evidence of bone density reading of WHO T-score less than -2.5? ☐ Yes ☐ No

If **Yes**, please state the exact bone density reading was done :

_____ (dd/mm/yyyy)

b (i) Was there history of osteoporotic fractures involving:

- femur ☐ Yes ☐ No

  If **Yes**, please state the exact date where the fracture occurred :

  _____ (dd/mm/yyyy)

- wrist ☐ Yes ☐ No

  If **Yes**, please state the exact date where the fracture occurred :

  _____ (dd/mm/yyyy)

- vertebrae ☐ Yes ☐ No

  If **Yes**, please state the exact date where the fracture occurred :

  _____ (dd/mm/yyyy)

(ii) Did any of the above fractures directly cause the patient's permanent inability to perform at least one of the activities of daily living? ☐ Yes ☐ No

If **Yes**, please state the commencement date and type of daily activity where patient is permanently unable to perform :

_____ (dd/mm/yyyy)

_____

Signature of Attending Doctor

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Date (dd/mm/yyyy) : _____

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SECTION 37 : SEVERE RHEUMATOID ARTHRITIS

a	(i)	Was there widespread joint destruction with major clinical deformity of the following joint areas:		
		▪ knees / ankles / feet (please circle the affected area)	☐ Yes	☐ No
		▪ spine	☐ Yes	☐ No
b	(i)	Was the diagnosis supported by all of the following:		
		▪ morning stiffness	☐ Yes	☐ No
		▪ symmetric arthritis	☐ Yes	☐ No
		▪ presence of rheumatoid nodules	☐ Yes	☐ No
		▪ elevated titres of rheumatoid factors	☐ Yes	☐ No
		▪ radiographic evidence of severe involvement	☐ Yes	☐ No
	(ii)	If answers to the above are **Yes** , please state the exact date of commencement and the date where the diagnostic test(s) were performed :	_____ (dd/mm/yyyy)	

SECTION 38 : DENGUE HAEMORRHAGIC FEVER

a	(i)	Was there history of continuous high fever for two or more days?	☐ Yes	☐ No
	(ii)	Was there minor or major haemorrhagic manifestations?	☐ Yes	☐ No
	(iii)	Was there thrombocytopenia of less than or equal to 100,000 per mm^3?	☐ Yes	☐ No
	(iv)	Was there haemoconcentration (haemotocrit increased by 20% or more)?	☐ Yes	☐ No
	(v)	Was there evidence of plasma leakage i.e. pleural effusion, ascites or hypoproteinaemia etc?	☐ Yes	☐ No
	(vi)	Was there evidence of Dengue Shock Syndrome (DSS) with:		
		▪ hypotension less than 80 mm Hg or narrow pulse pressure of 20 mm Hg or less?	☐ Yes	☐ No
		▪ tissue hypoperfusion such as cold, clammy skin, oliguria or metabolic acidosis?	☐ Yes	☐ No
b	(i)	Was there unequivocal evidence of DSS stage 3 or Stage 4 as defined by WHO with confirmatory serological testing?	☐ Yes	☐ No
		If **Yes**, please state the stage and exact date of serological test performed :		
		DSS Stage : _____	_____ (dd/mm/yyyy)	

SECTION 39 : TERMINAL ILLNESS

a	What is the diagnosis and prognosis of patient's illness?		
b	In your opinion, is the condition highly likely to lead to death within 12 months? If **Yes**, please provide your basis.	☐ Yes	☐ No
c	Is the condition present as a result of HIV / AIDS?	☐ Yes	☐ No

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SECTION 40 : MAJOR HEAD TRAUMA

a (i) What is the date of accident?

_____
(dd/mm/yyyy)

b (i) Where and how did the accident happen resulting in the major head trauma?

(ii) Did the injury result from a self-inflicted act? ☐ Yes ☐ No
If **Yes**, please provide details.

(iii) Was there reason to suspect that there were contributory circumstances which led to the injury, e.g. under the influence of alcohol, drugs, etc? ☐ Yes ☐ No
If **Yes**, please provide details.

(iv) Was there a police report made with regard to this accident? ☐ Yes ☐ No
If **Yes**, please provide a copy of the police report (if available).

c (i) Was there any form of neurological deficit still present 6 weeks after the date of accident? ☐ Yes ☐ No
If **Yes**, please state the neurological deficit(s).

(ii) Is this neurological deficit likely to be permanent? ☐ Yes ☐ No
If **No**, please state the date of recovery or date which the patient is expected to recover from the neurological deficit.

_____
(dd/mm/yyyy)

d (i) Did the patient undergo open craniotomy for treatment of depressed skull fracture or major intracranial injury? ☐ Yes ☐ No
If **Yes**, please provide details and attach a copy of the surgery note.

(ii) If the patient had suffered from facial injury, was there any re-constructive surgery above the neck to correct disfigurement (restoration or re-constructive of the shape and appearance of facial structures which are defective, missing or damaged or misshapened)? ☐ Yes ☐ No
If **Yes**, please provide details of the surgery performed.

e (i) Is the patient mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)? ☐ Yes ☐ No

f To be completed ONLY if the patient had accidental cervical spinal cord injury:

(i) Has the accidental cervical spinal cord injury resulted in the loss of use of at least one entire limb for at least 6 weeks from the accident? ☐ Yes ☐ No
If **Yes**, please provide details.

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Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____

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NRIC / Passport No : _____

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SECTION 41 : PROGRESSIVE SCLERODERMA

a Please provide a description of the extent of the illness.

b Does the illness involve the followings:

(i)	skin with deposits of calcium (calcinosis)	☐	Yes	☐	No
(ii)	skin thickening of the fingers or toes (sclerodactyly)	☐	Yes	☐	No
(iii)	the esophagus	☐	Yes	☐	No
(iv)	telangiectasia (dilated capillaries) and Raynaud's Phenomenon causing artery spasms in the extremities	☐	Yes	☐	No
(v)	heart	☐	Yes	☐	No
(vi)	lungs	☐	Yes	☐	No
(vii)	kidneys	☐	Yes	☐	No

c Please provide the results of investigations done and attach copy of the serology and biopsy report (if any)

SECTION 42 : PERSISTENT VEGETATIVE STATE (APALLIC SYNDROME)

a Is there presence of universal necrosis of the brain cortex with the brainstem intact? ☐ Yes ☐ No
If **Yes**, describe the neurological damage.

b Did the appallic syndrome persist for at least one month since its onset? ☐ Yes ☐ No
If **Yes**, please state the duration for which it persisted:

c Is the patient's condition in any way related or due to AIDS or HIV related illness? ☐ Yes ☐ No
If **Yes**, please provide details.

SECTION 43 : LOSS OF INDEPENDENT EXISTENCE

a Is the patient able to perform (whether aided* or unaided) for a continuous period of at least 6 months the followings:

(i)	Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means	☐	Yes	☐	No
(ii)	Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances	☐	Yes	☐	No
(iii)	Ability to move from a bed to an upright chair or wheelchair and vice versa	☐	Yes	☐	No
(iv)	Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene	☐	Yes	☐	No
(v)	Ability to move indoors from room to room on level surfaces	☐	Yes	☐	No
(vi)	Ability to feed oneself once food has been prepared and made available	☐	Yes	☐	No

* Aided shall mean with the aid of special equipment, device and / or apparatus and not pertaining to human aid

Signature of Attending Doctor

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Date (dd/mm/yyyy) : _____

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SECTION 44 : CROHN'S DISEASE

a Is there evidence of continued inflammation of the bowel in spite of optimal therapy? ☐ Yes ☐ No

b Has any of the following occurred?

(i) stricture formation causing intestinal obstruction requiring admission to hospital? ☐ Yes ☐ No

(ii) fistula formation between loops of bowel ☐ Yes ☐ No

(iii) resection of at least one bowel segment ☐ Yes ☐ No

c Please provide results of investigations done and attach copy of the pathology report (if any)

_____

SECTION 45 : ULCERATIVE COLITIS

a Please provide a description of the extent of the illness.

_____

_____

b Does the illness involve the followings:

(i) life threatening electrolyte disturbances usually associated with intestinal distensions and a risk of intestinal rupture ☐ Yes ☐ No

(ii) entire colon with severe bloody diarrhoea and systemic signs and symptoms ☐ Yes ☐ No

(iii) total colectomy and ileostomy ☐ Yes ☐ No

c Please provide the results of investigations done and attach copy of the biopsy report (if any)

_____

SECTION 46 : PHEOCHROMOCYTOMA

a Please provide a description of the extent of the illness.

_____

_____

b Was there secretion of excess catecholamines? ☐ Yes ☐ No

c Please provide the results of investigations done and attach copy of the biopsy report (if any)

_____

SECTION 47 : WILSON'S DISEASE

a Please provide a description of the extent of the illness.

_____

_____

b Does the illness involve the followings:

(i) a progressive liver disease ☐ Yes ☐ No

(ii) neurologic deterioration due to copper deposit ☐ Yes ☐ No

c Please provide the results of investigations done and attach copy of the biopsy report (if any)

_____

_____ _____

Signature of Attending Doctor | Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____ Date (dd/mm/yyyy) : _____

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DECLARATION OF BENEFICIAL OWNERSHIP

Is there a beneficial owner in receiving this payment? ☐ Yes ☐ No

If Yes, please provide the particulars of the beneficial owner(s) to this policy and submit a copy of their NRIC / Passport (certified by your servicing adviser) to us.

Name(s) : _____

NRIC / Passport No(s) : _____

Address(es) : _____

_____

Contact No(s) : _____ (H) _____ (O) _____ (HP)

Relationship to Deceased :

Nationality: ☐ Singaporean ☐ Singapore PR ☐ Others, please specify _____

Note:
Beneficial owner, in relation to a customer of a financial adviser, means the natural person who ultimately owns or controls a customer or the person on whose behalf a transaction is being conducted and includes the person who exercises ultimate effective control over body corporate or unincorporated.

_____
Signature of Claimant

Date : _____
(dd/mm/yyyy)

Name(s) : _____

NRIC No(s) : _____

Address(es) : _____

_____

Contact No(s) : (HP) _____

Relationship : _____

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TOKIO MARINE
INSURANCE GROUP

AUTHORIZATION FORM FOR MEDICAL REPORT

NAME OF PATIENT : _____

NRIC NO. : _____ POLICY NO. : _____

This consent form is required for an insurance claim.

Authorization

I / We hereby authorize:

(a) any medical source, insurance office, or organization to release to or when requested to do so by Tokio Marine Life Insurance Singapore Pte. Ltd. ("Company"), any relevant information concerning the above-named patient, and;

(b) the Company release to any medical source, insurance office, or organization, any relevant information concerning the above-named patient, at any time.

A photocopy of this authorization shall have the same effect as the original.

Yours faithfully

_____

Signature of *Patient / Patient's Parent / Guardian

Name : _____

Address : _____

_____

NRIC No. : _____ Relationship to patient : _____

* If the patient is below 21 years old, this form should be signed by the patient's parent / guardian

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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 Pte. 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 Pte. 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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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 Pte. 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: _____

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