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CREDIT INSURE GOLD HOSPITALIZATION BENEFIT CLAIM FORM

The Certificate sets out the exclusions on the policy. In this regard, please note the following :
(a) "Illness" in the Certificate has a defined meaning and will exclude pre-existing conditions. Please refer to the Certificate for more details.
(b) Coverage ceases when the Life Insured has attained the age of 65.
You are advised to refer to the Certificate for the complete list of exclusions and the details of each exclusion.

Hospitalization Benefit Claim

Part 1 : To Be Completed By The Insured Person

Please ensure that all information is fully completed so as to expedite claim settlement. Where it is not applicable to the claim, please write "NA". A photocopy of the billing statement before the hospital admission date and the following two months must be submitted. The delivery of this form to you is in no way an admission of claim.

Insured Person's Particulars

Insured Person's Name: _____ Sex: Male / Female * Age: _____

NRIC/FIN/PP No.* : _____ Date of Birth : _____

Address : _____ Tel. No. (O) : _____

_____ Tel. No. (H) : _____

Details of Illness

(a) Describe in detail all symptoms and/or nature of Insured Person's illness.

_____

_____

_____

_____

(b) Date when Insured Person first experienced these symptoms: _____/ _____/ _____
dd mm yyyy

(c) How long had the Insured Person been having these symptoms before he/she consulted a doctor?

_____

_____

_____

(d) Date when Insured Person first consulted a doctor for these symptoms: _____/ _____/ _____
dd mm yyyy

(e) What was the diagnosis?

_____

_____

_____

Manulife (Singapore) Pte Ltd.
Reg. No. 198002116D
8 Cross Street #15-01, Manulife Tower, Singapore 048424
Tel: 6737 1221 Website: www.manulife.com.sg

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(f) Date when Insured Person was diagnosed by a doctor : _____/ _____/ _____
dd mm yyyy

(g) Has the Insured Person previously suffered from or received treatment for a similar or related illness?

☐ Yes ☐ No

If "Yes", please provide the details.

_____

_____

_____

(h) Has the Insured Person previously been hospitalized?

☐ Yes ☐ No

Name/ Address of Hospital	Hospitalization period	Diagnosis

(i) Record of Medical Consultations

Please provide the names of the doctors Insured Person had consulted in relation to the illness at paragraph 3(a) and the addresses of the respective hospitals / clinics.

Name of Doctor	Name/ Address of Hospital/ Clinic	Dates of First Consultation

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DECLARATION AND AUTHORISATION

I/ We agree on my/ our behalf, Manulife (Singapore) Pte. Ltd. ("Manulife") is authorised to collect, retain, use and / or disclose as it reasonably deems fit, any information in respect of me, that is received by Manulife to its Representatives and relevant third parties (including but not limited to companies within the Manulife Group, reinsurers, medical organisations, my / our financial advisers, financial institutions, CPF agent banks, credit agencies, investigators, service providers, judicial, regulatory, government, statutory authorities, dispute resolution parties and industry entities) whether within or outside Singapore that is necessary to evaluate and process my/our claim in any way permitted or required by law. As far as reasonably possible, Manulife will release such information to such parties on the understanding that the information will be kept strictly confidential and be used, disclosed and retained in accordance with the relevant law. A copy of this authorisation shall be as valid as the original.

I/We understand the information obtained by the use of this Authorization will be used by Manulife to determine eligibility for benefits under the policy.

I/We jointly declare that all information/answers given by me/us in this form are, to the best of my/our knowledge and belief, accurate and complete. I/We consent to Manulife seeking/providing information about the deceased from/to any medical source, insurance office, organisation or person, governmental organisation, and/or regulatory body. A copy of this authorisation shall be as valid as the original.

Signature of Life Insured

_____

Name (as per NRIC):

Date:

Signature of witness

_____

Name (as per NRIC):

NRIC/PP No.:

Contact No.:

Date:

Points to note

I. Please note that the fee for completing the Attending Physician's Statement shall be borne by the life insured/ policyowner.
II. If you are asking another party to handle the claim process on your behalf, an authorisation letter is required.
III. Please continue to pay the premiums until the claim is approved.
IV. In order for us to process the claim, we will require the following:

1. Hospitalization Benefit Claim Form
2. Attending Physician's Statement
3. All available **Laboratory and Test Results**
4. Photocopy of Insured's last Citibank Credit Card Billing Statement as at the first day of hospitalization and photocopies of the Billing Statement for the following month
5. Upon receipt of **ALL** the above required documents, we will process your claim and inform you of the outcome as soon as possible. However, in certain circumstances, we may require further information after the above documents are received.

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PERSONAL DATA PROTECTION NOTICE

We will collect, use or disclose the personal data in this form to:

- confirm your identity and uniquely identify you;
- confirm the accuracy of the information collected;
- communicate with you, especially with respect to the claims submitted to us;
- assess, process, investigate or settle claims;
- detect and prevent fraud, unlawful or improper activities;
- comply with all legal and regulatory requirements within and outside Singapore including disclosures to judicial, regulatory, government, statutory authorities and industry entities;
- resolve complaints, and handle requests for data access or correction; and compliance monitoring and audit reviews.

A detailed list of purposes for which your personal data may be used or disclosed can be found in our statement of Personal Data Protection which is available at www.manulife.com.sg.

We will only collect and use personal data in a lawful way. We do not, without your consent, give your personal data to any person and/or entity for the purpose of that person and/or entity marketing its own products or services directly to you. We will use and disclose your personal data only with your consent or where such is permitted or required under any relevant law. Where personal data is provided to our service providers, we will require them to protect the personal data in a manner that is consistent with our personal data protection policies and practices

If you have any questions or concerns about our personal data protection policies and practices or wish to request access to, update or correct your personal data, please contact:

The Data Protection Officer
Manulife (Singapore) Pte. Ltd.
8 Cross Street #15-01
#15-01 Manulife Tower
Singapore 048424
Email: sgp_data_protection_office@manulife.com

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Part II – Attending Physician's Statement

This is to be completed by the Attending Physician at the Insured Person's own expense. All questions must be answered to expedite the claim assessment. Please provide copies of any relevant laboratory and medical reports to support the claim.

Patient's Particulars

Insured Person's Name: _____ Sex: Male / Female * Age: _____

NRIC/FIN/PP No.* : _____ Date of Birth : _____

Details of Hospitalization

1. Diagnosis : _____

2. Date of Diagnosis : _____/_____/_____
   dd mm yyyy

3. Date Diagnosis was made known to the patient : _____/_____/_____
   dd mm yyyy

4. Date of First Consultation for the medical condition : _____/_____/_____
   dd mm yyyy

5. Please state the symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms first started (dd/mm/yyyy)

6. Are you the patient's usual medical doctor? ☐ Yes ☐ No

7. If "Yes", since when? _____/_____/_____
   dd mm yyyy

8. Has the patient consulted any other doctor(s)/ hospital(s) prior to first consultation with you? ☐ Yes ☐ No

   If "Yes", please provide the name and address of the doctor(s)/ hospital(s).

   _____

   _____

   _____

   _____

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9. Referral Doctor (if any)

   a) If the patient was referred to you by another doctor, please provide the name and address of the referral doctor, and his/her diagnosis :

   Name : _____

   Address : _____

   _____

   Diagnosis : _____

   Date of Diagnosis : _____/_____/_____
   dd mm yyyy

   b) What was his/her advice and treatment given to the patient?

   _____

   _____

   _____

   _____

10. Is the condition a result of an accident? ☐ Yes ☐ No

    If "Yes", please describe in detail how the accident happened and the date of accident. If "No", please advise if the condition is self-inflicted.

    _____

    _____

    _____

    a) Was the patient under the influence of alcohol? ☐ Yes ☐ No

    If "Yes", what was the blood alcohol content reading?

    _____

    _____

    b) Was the patient under the influence of any drugs? ☐ Yes ☐ No

    If "Yes", please provide the name of the drugs and results of blood tests performed (if any)

    _____

    _____

11. For Female patients only : Was the patient pregnant at time of hospitalization? ☐ Yes ☐ No

    If "Yes", for how many months? _____

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12. Is the current treatment associated with the following : -

(i)	Pregnancy, childbirth or miscarriage or complications from pregnancy or childbirth	☐ Yes	☐ No
(ii)	Prenatal or postnatal care	☐ Yes	☐ No
(iii)	Birth control / Sterilisation	☐ Yes	☐ No
(iv)	Infertility/ Subfertility	☐ Yes	☐ No
(v)	Abortion	☐ Yes	☐ No
(vi)	Routine health check-up	☐ Yes	☐ No
(vii)	Dental care or surgery	☐ Yes	☐ No
(viii)	Alcoholism	☐ Yes	☐ No
(ix)	Drug addiction or abuse	☐ Yes	☐ No
(x)	Mental or nervous disorder or "rest cures"	☐ Yes	☐ No
(xi)	Birth defects	☐ Yes	☐ No
(xii)	Hereditary conditions	☐ Yes	☐ No
(xiii)	Congenital sickness or abnormalities	☐ Yes	☐ No
(xiv)	Obesity, weight reduction or weight improvement	☐ Yes	☐ No
(xv)	Sexually-transmitted disease, AIDS or any illness caused by or related to the Human Immuno-deficiency Virus (HIV)	☐ Yes	☐ No

13. Medical History

a) Has the patient previously suffered from the same illness that she was hospitalized? ☐ Yes ☐ No

If "Yes", please provide the following :

i) Date when illness was first diagnosed : _____/_____/_____
dd mm yyyy

ii) Name and address of the doctor who first treated him/her

_____

_____

Signature of Doctor

Date

Address & Official Stamp

Name and Qualification (printed)

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To Be Completed By Citibank

Please ensure that all information are fully completed to expedite claim settlement. Where it is not applicable to the claim, please write "NA". A photocopy of the billing statements for all eligible credit facilities before the event date and the following two months must be submitted. The delivery of this form to you is in no way an admission of claim.

Event Date : _____

Insured Person's Particulars

Insured Person's Name: _____ Sex: Male / Female * Age: _____

NRIC/FIN/PP No.* : _____ Date of Birth : _____

Address of Insured Person : _____ Tel. No. (O) : _____

_____ Tel. No. (H) : _____

Eligible Credit Facilities

Credit Card No : _____ Coverage Commencement Date : _____

Credit Card No : _____ Coverage Commencement Date : _____

Credit Card No : _____ Coverage Commencement Date : _____

Ready Credit A/C No: _____ Coverage Commencement Date : _____

Others - _____ Coverage Commencement Date : _____

Policy In Force At Event Date : **Yes** / **No**

Completed & Verified By:

Name of Citibank Officer : _____ Signature: _____

Designation : _____ Date : _____

**** Delete where not applicable***

Points to note
Please note that the claimant will have to complete a claim form and submit to Manulife together with the required supporting documents for our claims assessment.
Please be advised that further documents maybe required for the processing of the claim.

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