HSBC Life

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Outpatient
Claim Form

Policy No.

❏ Outpatient Claim ❏ Dental Claim

A. Employer (For Group Policy)

Full Name

B. Policyholder's (For Individual Policy) / Employee's (For Group Policy) Particulars

Full Name		
NRIC / FIN / Passport No.	Date of Employment	
Date of Birth (DD/MM/YYYY)	Nationality	Gender: ❏ Male ❏ Female
Contact Number (Mobile)	Email	

C. To be completed by Employer (For Group Policies)

Company Name	Plan No. / Plan Type
Date of Employment (DD/MM/YYYY)	Designation / Grade of Employee
Effective date of coverage (DD/MM/YYYY)	

D. Patient's Particulars (if Patient is a dependent of the Policyholder / Employee)

Full Name	
Relationship ❏ Spouse ❏ Child	NRIC / FIN / Passport No.
Date of Birth (DD/MM/YYYY)	Gender: ❏ Male ❏ Female

Is the Dependent: ❏ Employed ❏ Not Employed ❏ Enlisted in National Service

If Employed, please furnish the name of his / her Employer:____

E. Please complete if Outpatient / Dental Claim was due to an Accident (if applicable)

Date of Accident (DD/MM/YYYY)	Time of Accident
Place of Accident	
Describe how the accident happened (please enclose a copy of the police report, if any)	
Describe in details the injuries sustained, indicating the part of the body injured and the type of injury (eg. fracture, cut, bruise etc.)	
Was it work related? ❏ Yes ❏ No	Are you entitled to claim against Work Injury Compensation? ❏ Yes ❏ No Date first treated:____

F. Please provide details of outpatient claims (if applicable)

Date of Consultation (DD/MM/YYYY)	Date patient first experienced symptoms (DD/MM/YYYY)	Symptom(s) Presented	Diagnosis	Amount Incurred (Please state currency)

Was the patient ever hospitalised as the result of the above illness or accident? ❑ Yes ❑ No

If "Yes", please state the name of the hospital and the date(s) of admission and discharge

Name of the hospital	
Date of Admission (DD/MM/YYYY)	Date of Discharge (DD/MM/YYYY)

Name of address of patient's regular / family doctor

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G. Please provide details of dental claims (if applicable)

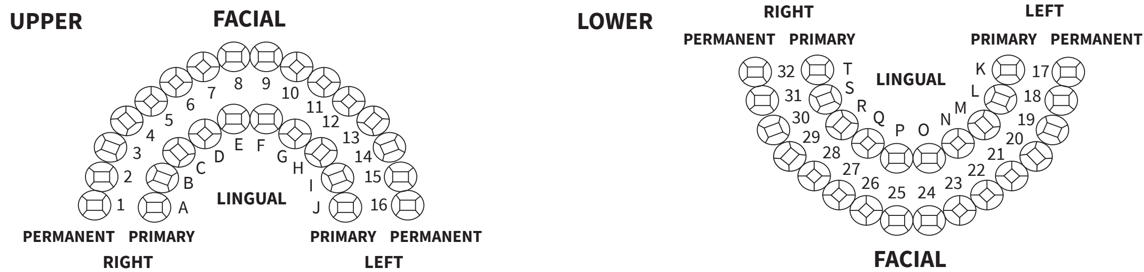
Date of Consultation (DD/MM/YYYY) ____________________________

Date patient first experience symptom(s) (DD/MM/YYYY) ________________________________

Chief complaint and main symptom(s)

❑ Routine dental care ❑ Oral and maxillofacial surgery ❑ Orthodontics / Aesthetics ❑ Congenital / Development ❑ Sports Related

Specify the recommended investigations, and / or procedures using the tooth number as shown the teeth map.



Please provide a breakdown of the incurred expenses

(a) Consultation / Examination	$
(b) X-rays	$
(c) Scaling and Polishing	$
(d) Filing	$
(e) Extraction - Routine / Difficult extraction	$
- Surgical extraction of wisdom tooth	$
(f) Medication	$
(g) Pulp / Root Canal Treatment	$
(h) Periodontal Treatment	$
(i) Crowning	$
(j) Others (Please specify)	$
Total	$

H. Other Information

Have you claimed or do you intend to claim from any insurer, other employer or any parties for reimbursement of your medical bills? ❏ Yes ❏ No

If "Yes", please state the party that you are claiming from and submit a copy of the settlement letter or payment voucher from the other party.

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Note: It is important that you inform us if you are claiming from another insurer, other employer or any other parties for the same bill(s). You can only be reimbursed once for the amount that you have incurred regardless of the number of medical insurance policies you may have. We reserve that right to recover if there is any excess amount paid to you.

I. Payment Details

1. Benefits should be made payable to

❏ Policyholder / Employer ❏ Claimant / Employee ❏ Third Party (for International Exclusive Policy only)

2. Payment is to be made by

❏ PayNow (**for Benefits+ policies only**) NRIC No. ________________________ (please ensure that PayNow is linked to your NRIC No.)

❏ GIRO* ❏ Overseas Telegraphic Transfer (for selected policies only)*

*Please complete section below on bank details

Name of Bank		
Name of Account Holder		
Bank Code	Branch Code	Account Number
Bank Address		
IBAN / SWIFT Code		

J. Declaration and Authorisation (this part must be signed by patient or patient's parent / legal guardian if patient is below 17 years of age

I/We confirm that I am/We are the claimant and/or the Policyholder and I/We declare that all the statements and answers stated are true and complete to the best of my/our knowledge and belief.

I/We hereby authorise HSBC Life (Singapore) Pte. Ltd. ("HSBC Life") to request from any physician, hospital, dentist, person or organisation (including the Policyholder (the "Employer"), all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment and copies of all hospital and medical records concerning me/us and/or my dependents (where applicable) at any time and authorise the prior mentioned organisations to disclose all such information to HSBC Life. A photocopy of this authorisation shall be considered as effective and valid as the original.

In connection with my/our claim, I/We give consent for HSBC Life (collectively "HSBC Life") and its respective representatives or agents to collect, use, store, transfer and/or disclose the information (including that provided by sources other than myself) concerning me/us and/or my dependents to or with all such persons (including any member of the HSBC Group or any third party service provider, and whether within or outside of Singapore and the Policyholder when claiming under a Group Policy) for the purpose of enabling HSBC Life to provide me/us and/or my dependents (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/or managing my/our claims or the Employer's Group Policy(ies) with HSBC Life (as the case may be), and for the purposes set out in the Data Use Statement which can be found at www.hsbclife.com.sg ("Purpose").

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Full Name, NRIC / FIN / PP no. & Signature of Claimant / Employee
(Parent's or Guardian's signature if patient is a minor)

Date (DD/MM/YYYY) ____

____

Full Name, NRIC / FIN / PP no. & Signature of Patient
(Parent's or Guardian's signature if patient is a minor)

Date (DD/MM/YYYY) ____