Critical Illness Claim Form

Important
We're sorry to receive notice of the life assured's condition. In order for us to process your claim, please complete this claim form in full and submit the following documents.

Documents required

1. This Critical Illness Claim Form (to be completed by claimant)
2. Critical Illness Claim - Attending Physician's Statement (to be completed by attending doctor)
3. FWD Consent form
4. Copies of all diagnostic reports, including resting ECGs, exercise stress test, troponin results, enzymes assays, isotope studies imaging coronary angiography, blood tests, ultrasound, biopsy, histopathology report, CT scans, other imaging studies, laboratory tests results, detailed inpatient discharge summary and any relevant hospital reports that are available
5. Toxicology report report (if any)
6. Police investigation report (if any)
7. Copy of the NRIC/FIN/Passport of the life assured
8. Copy of the NRIC/FIN/Passport of the claimant, if different from the life assured
9. Any other documents that support the claim (e.g. official certificate of appointment of the legal guardian of life assured who is a minor)

* For item 2 and 3, we will provide to you the Critical Illness Claims - Attending Physician's Statement and Consent Form upon receipt of completed Critical Illness Claim Form

Proof of Life Assured's Relationship With Claimant As Follows (Where Applicable)

Life assured	Documents required
Spouse	Marriage certificate of life assured
Children	Birth certificate of life assured's child
Parent	Birth certificate of life assured and claimant
Sibling	Birth certificate of life assured and claimant

Important notes

1. All documents that are not issued in Singapore must be authenticated by either i) the Singapore Embassy in the country of death/incident, ii) Singapore Consulate or iii) Notary Public.

2. These documents shall be in the forms as prescribed and shall be furnished at the expense of the Claimant(s).

3. All documents submitted must be in English. Any document that is not in English must be accompanied by an English translated copy of the document made by a certified translator/interpreter.

4. All questions in this claim form must be fully and truthfully answered. The Company reserves the right to require or obtain further information, if deemed necessary.

5. The acceptance of this form is NOT an admission of liability on the part of FWD.

6. Please note that, under the policy terms and conditions, the policy may be void if any information provided in this claim form is made knowingly by you that it is materially false or misleading.

7. The Company reserves the rights to request for additional documents when deemed necessary.

8. Please continue paying your premiums to keep your cover active.

Policy number

Details of Life Assured

Name of life assured

NRIC/FIN/Passport

Marital status

Address

Contact no

Email

Occupation

Name and address of employer

Details of Illness

How long did you have the symptoms before you consulted a doctor?

Please provide details of the symptoms you experienced that led to you visiting a doctor

Date you first consulted a doctor for this condition (dd/mm/yyyy)

Please provide the name and address of the doctor whom you had first consulted for this illness

Date of diagnosis (dd/mm/yyyy)

Name and address of the doctor who confirmed the illness/ diagnosis

Details of diagnosis

Have you previously experienced or are you being treated for any similar or related illness?

Details of any other doctor(s) consulted for this illness & date of the consultation

Name & address of other doctors

Description of first symptoms

Date of first consultation

Treatment provided

Have you been hospitalised for condition(s) related to this illness? If "yes", please state name of hospital, date of admission, date of discharge and reason for hospitalisation

Details of Illness (If it was a result of an Accident)

Date of accident (dd/mm/yyyy)

Place of accident

Time of accident

Please describe the details of how the accident occurred

Nature and extent of injuries

Was the accident reported to the police? If "yes", please provide a copy of the police report

Details of Other Disorders/Conditions

Name & address of doctor who confirmed the illness/diagnosis

Date of first consultation

Date of last consultation

Reason for consultation

Treatment provided

Other Insurance

Does the life assured have any other insurance policy?

Name of Insurance Company/Type Of Plan/Date of Issue/Sum Assured

Are there any claims submitted or to be submitted to any other Insurance Company in respect of this illness?

Please Provide Detail Of Life Assured's Regular Doctor(S)

Name and Address of Hospital/Clinic

Date of consultation

Reason(s) for consultation

Mode of Payment

Once approved, your claim amount will be credited into your bank account. Kindly provide your bank account details.

☐ **Bank transfer** ☐ **Cheque**

Name of bank

Account holder's name

Account number

If you prefer to receive a cheque, kindly let us know.
Cheque (to be sent to the official address stated in the policy).

Declaration, Authorisation and Consent to use Personal Data

1. I certify that the information provided in this form is true and complete and I have not withheld any material information that could affect this claim.

2. For the purposes of policy administration, which includes the processing and/or investigation of this claim, I hereby:
   a. authorise any person or organisation who has relevant information on this claim, including but not limited to any medical practitioner, health care provider, clinic, hospital, insurance company and/or investigative agency, to release and exchange any and all information (including personal health information) requested by FWD Singapore Pte. Ltd. and/or its claims service providers;

   b. authorise FWD Singapore Pte. Ltd. and/or its claim service providers to collect, use, disclose and/or exchange with such persons or organisations referred to in (a) above any and all relevant information (including personal health information); and

   c. confirm that I am authorised to disclose information (including personal health information) about the insured person if this claim is made on his/her behalf.

3. I also give consent for FWD Singapore Pte. Ltd. to collect, use or disclose my personal data for audit, business analysis, reinsurance purposes and for the purposes set out in FWD's Privacy Policy, which can be found at www.fwd.com.sg.

4. I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

5. My signature below will signify my consent.

Signature of Life Assured/Claimant

Signed and Declared in Singapore on
(dd/mm/yyyy)

Name of Life Assured/Claimant

Relationship with Life Assured

Contact Number

Email