Manulife

CIMB BANK CREDIT PROTECT TPD/TTD CLAIM FORM

Please tick [√] in the appropriate box.
*An extract of some of the Benefits which **will not be payable**, namely :*
(a) Pre-existing condition (see item 2.12 ON "Illness" of the Certificate).
*(b) for first 30 days of total & temporary disablement (TTD) or where the event occurs as a result of any disease or sickness **occurring within 28 days of the commencement or last reinstatement date**. No TTD benefit is payable when you are still gainfully employed during the disability. (see items 2.13, 2.17, 2.21, 4.2, 4.3, 5 of the Certificate).*
(c) if you have attained age of 65 years, at which time your cover will automatically cease (see 5.6.2 of the Certificate).
For details of complete Coverages and Exclusions, please refer to your Credit Protect Certificate.

Part I – To Be Completed By Claimant

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 last billing statement to support your claim must be attached. The delivery of this form to you is in no way an admission of claim.

Visa Card No : _____ Credit Limit: _____ Credit Protect Start Date: _____

Master Card No: _____ Credit Limit: _____ Credit Protect Start Date: _____

Others - _____ Credit Limit: _____ Credit Protect Start Date: _____

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

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

Address of Insured : _____ Tel. No. (Office) : _____

_____ Tel. No. (Residence) : _____

Name of Claimant _____ NRIC/FIN/PP No * : _____
(If not the Life Insured)

Address of Claimant: _____ Relationship to Life Insured: _____

_____ Telephone No. : _____

1. Date of Illness/ Injury *: _____ Place of Injury* : _____

2. Cause of Illness/Injury *: _____

3. Period of Disability (*Applicable to TTD or TPD*) : From _____ To _____

4. Occupation before Disability : _____ Date last attended Work: _____

Name of Employer : _____

Address of Employer : _____

Give details of exact duties before disability : _____

5. Current Occupation (if different from above): _____ Date commence work: _____

Name of Employer : _____

Address of Employer : _____

Give details of exact duties after disability: _____

6. Details of regular Doctor or any other **Doctors consulted** by the life insured in the **past 3 years**.

Name & Address of Doctor(s)	Consultation Date	Reason for consultation

Manulife (Singapore) Pte Ltd. Reg. No. 198002116D
51 Bras Basah Road, #09-00, Manulife Centre, Singapore 189554
Tel: 67371221 Fax: 67378488 Website: www.manulife.com.sg

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Part I – To Be Completed By Claimant

7. Details of Doctor(s) consulted or Hospital(s) admitted for the disability now claiming.

Name & Address of Doctor(s)	Admission Dates	Symptoms	Diagnosis

8. Has the life insured previously sought any treatment for the disability which is now claiming? ☐ Yes ☐ No

If Yes, please provide following information :

Name & Address of Doctor(s)	Date of Treatment	Nature of Disability

9. Has the life insured ever claim Total & Permanent Disability Benefits? ☐ Yes ☐ No

If Yes, please provide following information :

Name & Address of Company	Policy No.	Amount Claimed	Cause of Claim

DECLARATION:

I hereby declare I am the person referred to or the Legal Representative of the person referred to in the above statements and answers given are true and complete to the best of my knowledge and belief. I have not made any false or fraudulent statement, any suppression and concealment of facts. I hereby claim the said benefit to be paid to the credit of the card amount nominated.

I consent to **MANULIFE (SINGAPORE) PTE LTD**, obtaining information in connection with this claim from any practitioner, hospital, specialist, clinic, employer, or any other person or organisation the Company deems necessary and I authorise the giving of such information. I agree that a photocopy of this authorisation is as valid as the original.

Dated at _____ this _____ day of _____ 20 _____

Signature of Claimant : _____

Name of Claimant : _____

Address : _____

_____

_____

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Part II – Attending Physician's Statement – Total & Temporary Disability / Total & Permanent Disability

This is to be completed by Attending Physician at Insured's/Claimant's own expense. All questions must be answered which will help expedite in claim assessment supported with any relevant medical reports.

1. Name of patient: _____ NRIC/FIN/PP No*: _____

2. Consultation For present Illness / Injuries :

(a) When did the patient first consult you for this illness or injury/ies? _____

(b) Were the patient referred by any other Medical Practitioner? If "Yes", please provide date referred, name and address of doctor or clinic / hospital.

_____

_____

3. If consultation was for illness, please provide the following information.

(a) Symptoms presented : _____

(b) Duration of these symptoms : _____

(c) Details of diagnosis : _____

(d) Was the diagnosis made known to the patient? If "Yes", when? If "No", why? ☐ Yes ☐ No

_____

_____

4. If consultation was for injury/ies, please describe injury/ies.

(a) Nature & severity of disability : _____

_____

_____

(b) To what extend does the patient disability prevent him from performing all the normal duties of his usual occupation?

_____

_____

_____

(c) Date patient was obliged to cease work : _____

(d) When do you consider patient will be fit to resume work? _____

(e) If he is unable to return to his usual occupation, can he engage in any other type of occupation?

_____

_____

(f) Please describe treatment, including any operations performed.

_____

_____

_____

Delete where not applicable

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5. Has patient been admitted to hospital before for the same illness / injury/ies? ☐ Yes ☐ No

If "Yes", please state:

(a) Date admitted : _____ (b) Date Discharged : _____

(c) Name of Hospital : _____ (d) Admission No : _____

6. Has patient suffered or is suffering from any other disease or ailment? ☐ Yes ☐ No

If "Yes", please give details

(a) Date patient first suffered from the disease or ailment: _____

(b) Diagnosis & Treatment : _____

(b) Name & Address of physician consulted: _____

7. In your opinion, is the disability "total & permanent and such that there is neither then nor at any time thereafter any work, occupation or profession that the person concerned can ever sufficiently do or follow to earn or obtain any wages, compensation or profit"? Please state your opinion and if "yes", when such disability commenced.

_____

_____

_____

_____

_____

8. Please provide us with any other additional information that will enable the Company to assess this claim.

_____

_____

_____

_____

_____

Signature : _____

Name of Physician: _____

Qualification : _____

Date : _____

Practice Stamp & Address :

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