



## HEALTHCARE MEDICAL CLAIM FORM

Please note that this form is issued without admission of liability. Please state all relevant information requested as completely and accurately as possible.

Note: Please use a new claim form for each separate claim on illness

Please  tick where applicable.

### PARTICULARS OF INSURED (COMPANY / INDIVIDUAL)

Name \_\_\_\_\_ Policy No \_\_\_\_\_  
 GST Registration No<sup>+</sup> \_\_\_\_\_ Effective Date of Registration<sup>+</sup> \_\_\_\_\_  
 Business/Home Address\* \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Tel \_\_\_\_\_ (H) \_\_\_\_\_ (O) \_\_\_\_\_ (Hp) \_\_\_\_\_  
 Email \_\_\_\_\_

### PARTICULARS OF INJURED PERSON / PATIENT

Name of Injured Person/Patient (As in NRIC/Passport) Mr/Mrs/Ms/Mdm/Dr\* \_\_\_\_\_  
 Occupation \_\_\_\_\_ NRIC/Passport/BC No \_\_\_\_\_  
 Relationship to Insured \_\_\_\_\_ Gender  Male  Female Date of Birth \_\_\_\_\_  
 (dd/mm/yy)  
 Tel \_\_\_\_\_ (H) \_\_\_\_\_ (O) \_\_\_\_\_ (Hp) \_\_\_\_\_

\* If applicable \* Delete if not applicable

### DETAILS OF CLAIM

#### SICKNESS

Nature of Illness/Final Diagnosis \_\_\_\_\_ Date symptoms first started \_\_\_\_\_  
 Nature of Treatment/Operation \_\_\_\_\_  
 Attending Doctor's Name and Address \_\_\_\_\_

#### ACCIDENT

Date \_\_\_\_\_ Time \_\_\_\_\_ am/pm\* Place \_\_\_\_\_  
 Date first treated \_\_\_\_\_ Nature of Injury \_\_\_\_\_  
 Describe how accident happened \_\_\_\_\_

Attending Doctor's Name and Address \_\_\_\_\_

#### OTHER INSURANCE OR COMPENSATION

1. Is the Insured or Patient presently also insured for medical under another Insurance Company? \_\_\_\_\_  Yes  No  
 If Yes, please state Name of Insurance Company and Policy No \_\_\_\_\_
2. Is the Insured or Patient claiming from another Insurance Company/other sources? \_\_\_\_\_  Yes  No  
 If Yes, please provide a copy of their settlement details.

### SUPPORTING DOCUMENTS

1. Final original detailed hospital bills or receipts
2. Final original clinic bills or receipts

### DETAILS OF PAYEE ( To be completed by company only)

Name of Payee<sup>^</sup> (Name as in bank account) \_\_\_\_\_ Amount \_\_\_\_\_

<sup>^</sup> Payee should be the Employer or Insured Person only. Payee shall not include clinic, physician and any other medical providers. Please write the payee in capital letters and amount clearly and accurately to avoid any delay in cheque issuance.

### DECLARATION

I hereby authorise any hospital, physician, person or organization to disclose all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records. A photocopy of this authorisation shall be considered as effective and valid as the original.

I declare that the information given is true and correct to the best of my knowledge and belief. I understand that any false or fraudulent statements or any attempt to suppress or conceal any material facts shall render the policy void and the Insurer may refuse to pay the claim.

Signature of Insured \_\_\_\_\_ Signature of Injured Person / Patient \_\_\_\_\_

Company's Stamp \_\_\_\_\_ Date \_\_\_\_\_

The Claimant must obtain at his/her own expense the medical report from his/her Medical Attendant.

TO BE COMPLETED BY ATTENDING PHYSICIAN / SURGEON

1) Name of Patient \_\_\_\_\_ NRIC No \_\_\_\_\_

2) Admission Period \_\_\_\_\_

3) Final Diagnosis (Based on ICD, 1975 Revision, WHO) of illness\* or extent of injury \_\_\_\_\_  
\_\_\_\_\_ DGR Code \_\_\_\_\_ ICD Code \_\_\_\_\_ ICD Code \_\_\_\_\_

4) What is the cause of the illness / injury? \_\_\_\_\_

5) Is the condition/treatment related to:

a. Pregnancy or childbirth \_\_\_\_\_  Yes  No

If Yes, please elaborate \_\_\_\_\_

b. Abortion or Miscarriage \_\_\_\_\_  Yes  No

If Yes, please elaborate \_\_\_\_\_

c. Infertility or Sub-fertility Condition \_\_\_\_\_  Yes  No

If Yes, please elaborate \_\_\_\_\_

d. Congenital Anomaly \_\_\_\_\_  Yes  No

If Yes, please elaborate \_\_\_\_\_

e. Genetic or Chromosomal Disorder \_\_\_\_\_  Yes  No

If Yes, please elaborate \_\_\_\_\_

f. Mental or Psychiatric Condition \_\_\_\_\_  Yes  No

If Yes, please elaborate \_\_\_\_\_

g. Cosmetic Surgery \_\_\_\_\_  Yes  No

If Yes, please elaborate \_\_\_\_\_

6a) How long had the patient been troubled by symptoms prior to the diagnosis? \_\_\_\_\_

b) In your medical opinion, how long do you think the illness existed prior to your diagnosis? \_\_\_\_\_

7) Did the patient have any symptoms prior to consulting you?  Yes  No If Yes, please indicate the nature of Symptoms and date Symptoms first started \_\_\_\_\_

8) When did the patient first consult you for this condition? \_\_\_\_\_

Nature and Date of Treatment rendered \_\_\_\_\_

9) Has the patient ever had the same or similar condition/symptom?  Yes  No  Not to my knowledge

If Yes, please indicate when and describe \_\_\_\_\_

Doctors previously consulted by the patient for the above condition:

Name	Date	Name of Clinic	Address
_____	_____	_____	_____
_____	_____	_____	_____

10) Describe the surgical procedures or treatment rendered. If no surgery was performed, please state treatment/medication given.

Date surgical procedures or treatment rendered: \_\_\_\_\_

If excision was performed, please indicate the size of the lesion/tumor (Please attach a copy of the Histology Report)

Name of a) Physician \_\_\_\_\_ b) Surgeon \_\_\_\_\_ c) Anaesthetist \_\_\_\_\_

What is the prognosis of this illness? \_\_\_\_\_

Is the surgery done for cosmetic reasons?  Yes  No If No, please explain why surgery was necessary.

Is the patient still under your care for this condition?  Yes  No If No, please give date service was terminated, and furnish name and address of doctor if the patient has been referred to another doctor for follow-up \_\_\_\_\_

\*Please tick the appropriate illness classification:

- Alimentary system, includes liver & biliary tract
- Musculo-skeletal system & connective tissue disorder
- Haematological disorders/autoimmune disorders
- Diseases of skin and subcutaneous tissue
- Symptoms, signs and ill-defined conditions
- Diseases of genito-urinary system

- Diseases of the nervous system
- Cancer/malignant tumour growth
- Respiratory System
- Cardiovascular system
- Ear, nose & throat system
- Psychological/Psychiatric

- Metabolic & endocrine disease
- Eye
- Female diseases/condition
- Infectious diseases
- Dental/bucco-mucosal

Signature of Physician/Surgeon \_\_\_\_\_

Date \_\_\_\_\_

Name/Designation \_\_\_\_\_

Name and Address of Clinic/Hospital \_\_\_\_\_