

Tenet Insurance Company Ltd

(A wholly owned company of Hwa Hong Corporation Limited)
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Company Registration No. 195700067Z <http://www.tenetinsurance.com>



HOSPITAL AND SURGICAL CLAIM FORM

Important Notice :

- 1 The acceptance of this form is NOT an admission of liability on the part of the Company.
- 2 All original final bills, certificates, supporting documents should be provided to substantiate your claim.
- 3 All medical reports must be submitted at the claimant's expense before a claim can be admitted.
- 4 Please answer in full all applicable questions as incomplete answers may delay claims settlement.

Agency _____ Policy No _____

1. INSURED'S PARTICULARS

a. Name of Insured

b. Address

c. Contact Nos.

(Res) _____ (O) _____ (HP) _____

2. CLAIMANT'S PARTICULARS

a. Name and nature of relationship of Claimant to Insured

Insured Dependant of Insured Employee Dependant of Employee

NRIC / Passport No. of Claimant: _____

b. Female Male / Age _____ Date of birth _____ / Married Single

c. If Dependant state relationship to Insured / Employee

Husband / Wife Son Daughter Parent

d. Is Dependant employed? No Yes Occupation : _____

e. If Employee, state date of employment and occupation

Date: _____ Occupation: _____

3. DETAILS OF ILLNESS / INJURY

a. Please state exactly what happened (if insufficient space, please attach statement).

b. Nature of illness (describe symptoms suffered) / Injury (eg, fracture, cut, bruise etc.)

c. Date symptoms first commenced / Date of Accident: _____

Date condition was first treated: _____

d. Is illness still being treated?

Yes. State nature of ongoing treatment and approximate date of completion.

No. State date of last treatment or appointment.

e. Has the claimant even seen a doctor or been treated for any similar condition in the past? Yes No

If yes, state date of previous treatment and name and address of attending doctor for previous treatment.

f. Is injury work related: Yes No

4. GENERAL INFORMATION

a. Name and Address of Regular Physician if different from Attending Physician.

b. Are you entitled to receive compensation from any other source for this illness / injury? Yes No

If yes, state: From what source :

To what extent :

c. Have you ever made a claim for compensation in respect of illness or accidental injury from any Insurance Company?

Yes No If yes, give particulars.

5. PAYMENT DETAILS

a. Please confirm payee name if claim is payable

Kindly arrange for your doctor to complete the Medical Certificate of Treatment Form.

DECLARATION AND AUTHORISATION - to be signed by the claimant

I declare that the particulars stated above are true and correct and I understand that if I have in this or in any further declaration in respect of this claim, made any false or fraudulent statement or suppress conceal or falsely state any material fact whatsoever my claim may be refused. I/We further authorise the Company to treat the submission of this form as my/our making a claim under my/our policy.

I hereby authorize any hospital physician, other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, 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.

Signature of Claimant

Date