Liberty Insurance Pte Ltd
51 Club Street #03-00 Liberty House
Singapore 069428
Tel: 1800-LIBERTY (542 3789)
Fax: (65) 6223 6434
Reg. No. 199002791D | GST Reg. No. M2-0093571-3
www.libertyinsurance.com.sg

Claims Form: Medical

Please complete all sections to facilitate the processing of your application. This form is issued without admission of liability and it must be completed and returned to us immediately, whether or not a claim is made. Any documentary proof or report required by liberty shall be furnished at the expense of Policyholder or Claimant.

Information of Policyholder

Name of Policyholder: ____________________		Policy No.: ____________________
Is Policyholder GST – registered?	Yes	No
If Yes, is Policyholder allowed to claim the GST on the Insurance Premium paid?	Yes	No
Email: ____________________		

Information of Claimant

Name of Claimant: ____________________		Policy No.: ____________________
Mailing Address: ____________________		Postal Code ( )
NRIC/FIN/Passport No.: ____________________	Date of Birth: ____________________	Contact No.: ____________________
Occupation: ____________________	Date Employed: ____________________	Gender: Female Male
Email: ____________________		
Is the condition/disability suffered due to:	Illness	Accident

If the condition/disability suffered is due to illness, please provide the following:

i. Diagnosis: ____________________

ii. Date of symptoms started: ____________________

iii. Details of all symptoms and nature of medical condition/disability suffered: ____________________

Detailed description of injuries/disability suffered: ____________________

Claims Form: Medical

Information of Claimant

If disability is due to accident, please provide detailed description of accident (Please enclose a copy of the police report if any): ______		
Did you seek medical treatment prior to being diagnosed with the illness for which you are now claiming? If Yes, please state:	Yes	No
Name of Physician: ______		
Mailing Address: ______	Postal Code ( )	
Are you claiming from any other insurer in respect of this illness/injury? If Yes, please state:	Yes	No
Name of Insurance Company: ______	Policy No.: ______	

Details of Accident

Date of Accident: ______	Time of Accident: ______	Place of Accident: ______		
How did the accident happen? ______		Road-related	Yes	No
		Work-related	Yes	No
		Others	Yes	No
Describe the Nature of Injuries sustained: ______				

Bank Account Information for Electronic Transfer

Name of Bank: ______	Bank Code: ______	Branch Code: ______
Bank Account No.: ______	Name of Bank Account Holder: ______	

I agree to hold Liberty Insurance Pte Ltd harmless and that it is fully and finally discharged of its obligations once it has made payment to the bank and bank account number given above.

PERSONAL DATA PROTECTION

I give consent to Liberty Insurance Pte Ltd and third-parties including related entities, employees, agents, other insurers, contractors & service-providers (collectively, “Appointees”) to collect, use and disclose all personal data relating to myself or other individuals that I have furnished in the past, present & in the future, for one or more of the purposes described in Liberty’s Data Protection Policy, including but not limited to considering whether to provide insurance, carrying out due diligence, pricing, administering and servicing my policies, communicating with me, renewals, reinsurance, collections, claims, accounting, audit, legal, compliance, research, analysis, information-sharing, surveys, data storage & backups. I have read and agreed to the full Policy at www.libertyinsurance.com.sg/data-protection-policy/. If there is any personal data relating not to myself but to other individuals that I have furnished in the past, present & in the future, I warrant that I have obtained prior consent from these data subjects (or if they are lacking in legal capacity, from their legal representatives, guardians or parents as the case may be) for Liberty Insurance Pte Ltd and its Appointees to collect, use and disclose their personal data for the abovementioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform Liberty of any changes to the personal data to my knowledge as soon as practicable.

DECLARATION

1) I declare that I have complied with the conditions and warranties (if any) of the Policy and in no manner deliberately caused the said loss or damage or exaggerated the claim or sought unjustly to benefit by any fraud or willful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty Insurance reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.

   I authorize the release of any medical information necessary to process this claim.

____
Date

____
Signature of Claimant

____
Date

____
Signature of Policyholder & Company Stamp

Claims Form: Medical

Medical Information (to be completed by the attending physician)

Name of Patient: ________________	NRIC/FIN/Passport No: ________________
Date when the patient first consulted you: ________________	Prior to the first consultation with you, when did the patient first suffer the symptoms of the condition: ________________
Presenting complaints:	________________
Was the Patient referred by another physician? Yes No If Yes, please provide details: Name of Physician: ________________ Mailing Address: ________________	Contact No.: ________________ Postal Code ( )
State your diagnosis of the illness/injuries:	________________
Details of Surgical Operation(s)/Procedure(s) done:	________________
Date of Admission: ________________	Date of Discharge: ________________

Is there any connection between the present condition and any other pre-existing illness or previous accident? Yes No

If Yes, please provide details:

____

Is the Condition of the Patient:

Attempted Suicide	Yes	No
Drug/Alcohol related	Yes	No
Genetic or chromosomal disorder	Yes	No
Hereditary or Congenital in nature	Yes	No
Infertility related	Yes	No
Pregnancy related	Yes	No
Psychological/Mental Condition	Yes	No
Related to cosmetic treatment	Yes	No
Self-inflicted injury	Yes	No
Sexually transmitted disease	Yes	No

If any of the above is Yes, please provide details:

____

Claims Form: Medical

Medical Information (to be completed by the attending physician)

Is the Condition of the Patient related to an Accident? If Yes, please provide details of the Accident, whether it is work-related and if police report was made? ____	Yes	No
Will illness/injury require further follow-up treatment If Yes, please provide details: ____	Yes	No
Any other relevant information: ____		

Please furnish copies of all the reports/investigations results.

I declare that I have in no manner deliberately exaggerated the claim or sought unjustly to benefit by any fraud or willful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty Insurance reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.

I authorize the release of any medical information necessary to process this claim

____

Date

____

Signature of Physician

Name of Physician:

Contact No.:

Company Stamp: