Liberty Insurance

www.libertyinsurance.com.sg

Claim Form

Outpatient-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.

1. Please complete and submit this claim form with all original bills/invoices/receipts to us within 30 days from date of consultation.
2. Please use one (1) claim form for each claimant.

For Outpatient Specialist/Diagnostic X-rays & Labs Tests claims

A. Visit at Government/Restructured Hospital
   - For 1st time visit, referral letter from Registered Medical Practitioner is required
   - Subsequent visit for the same medical condition, no referral letter is required
   - Copy of existing referral letter is required if Claimant is claiming for existing medical condition from Liberty Insurance for the 1st time

B. Visit at Private Hospitals/Specialist Clinics
   - For 1st time visit, referral letter from Registered Medical Practitioner is required
   - Referral letter is valid for **one (1) year** from date of referral. Thereafter, Claimant has to submit new referral letter for specialist visit

Information of Policyholder (Employer)

Name of Policyholder (Employer):	**Policy No.:**
_____	_____
Mailing Address: _____	Postal Code ( )
Email: _____	**Contact No.:** _____

Information of Insured Member (Employee)

Name of Insured Member (Employee):		**Gender:** ☐ Female ☐ Male
Date of Employment: _____	**NRIC/FIN No.:** _____	**Date of Birth:** _____
Occupation: _____		

Information of Claimant (Dependant)

Name of Claimant (Dependant):		**Gender:** ☐ Female ☐ Male
Relationship: ☐ Child ☐ Spouse	**NRIC/FIN No.:** _____	**Date of Birth:** _____

Details of Claims

Nature of Illness/Diagnosis/Injury	Date of Treatment	Amount Incurred	Amount Payable	Claim No./Type of Product

Claims Payment Details

Claim amount to be made payable to:	☐ Employer	☐ Employee
Claim amount in:	☐ Check	☐ Credit to the following bank account via GIRO

Bank Account Information for Electronic Transfer

Name of Bank:	**Bank Code:**	**Branch Code:**
_____	_____	_____
Bank Account No.:	**Name of 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 Employee

_____ _____

Date Signature of Policyholder & Company Stamp