

GROUP HOSPITAL & SURGICAL CLAIM FORM

- (1) For admission in a Private Hospital or Overseas Hospital, please complete Parts A & B of this form and request your attending doctor to complete Part C at your own expense.
- (2) For admission in a Singapore Government/Restructured Hospital
 - Complete Parts A & B of this form.
 - Provide a copy of the Inpatient Discharge Summary or alternatively complete Part C of this form.
- For the completion of Part C**, send the GH&S claim form with Part A & B duly completed to the Medical Records Section of the hospital, together with a cheque payable to the hospital (\$128.40 for SGH, \$139.10 SIN/PR or \$166.92 Non-Resident for KKH, \$80.25 for NUH, \$88 for NTFGH, \$80 for KTPH and \$90 for TTSH & CGH.). If the claim is payable, we shall reimburse you the medical report fee up to maximum of \$75 subject to the Other Hospital Services benefit.
- (3) Submit the completed claim form together with the original FINAL hospital/doctor's bills with approved Medisave/Shield deductions.
- (4) For payment via GIRO, please submit a copy of bank account statement. (This is not required if you have already provided us in your previous claims.)
 (We reserve the right to request for further documents or apply for further medical reports upon our receipt of the above documents.)

Part A (to be completed by the Employer & all fields are mandatory)

Name of Company	: <input type="text"/>	Policy No. :	<input type="text"/>
Name of Employee	: <input type="text"/>	NRIC/PP No. :	<input type="text"/>
Date of Employment	: <input type="text"/>	Date of Birth :	<input type="text"/>
	<small>DD MM YYYY</small>		<small>DD MM YYYY</small>
Job Designation	: <input type="text"/>	Sex :	Male <input type="checkbox"/> Female <input type="checkbox"/>
H & S Plan	: <input type="text"/>	Marital Status :	Single <input type="checkbox"/> Married <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Company's Stamp, Name and Signature of the Officer-in-charge.		Contact No. of Officer-in-charge	Date

Part B (to be completed by the Claimant)

1. Claimant's Details (to be completed if the Claimant is not the Employee) :

Name of Claimant	: <input type="text"/>	NRIC/PP No. :	<input type="text"/>
Occupation	: <input type="text"/>	Date of Birth :	<input type="text"/>
		<small>DD MM YYYY</small>	
Relationship to Employee	:	Spouse <input type="checkbox"/>	Child <input type="checkbox"/>
		Sex :	Male <input type="checkbox"/> Female <input type="checkbox"/>

2. Claim Information :

For hospitalisation due to accident :

Date of accident	: <input type="text"/>	Time of accident :	<input type="text"/>	Is this accident work-related? :	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	<small>DD MM YYYY</small>					
How did the accident occur?	:	<input type="text"/>				
Nature of injuries sustained	:	<input type="text"/>				

For hospitalisation due to illness :

Diagnosis/description of symptoms :	<input type="text"/>	Type of operation :	<input type="text"/>
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Other Information :

Are you making a claim from other insurance companies first? : Yes No If yes, state insurance company :

(Please submit a copy of the other insurance company's claim settlement letter.)

3. Payment Information :

Payment by: Cheque to Company Cheque to Employee Giro to Employee's account

(We will pay to the employee by cheque if the above selection is not completed. The Medisave amount will be credited directly to the CPF account stated on the hospital bill.)

For payment via GIRO, please complete the Employee's bank details below *(You do not have to complete this field if you have provided us details previously):*

Bank code:	<input type="text"/>	Branch code:	<input type="text"/>	Account no:	<input type="text"/>
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(We will pay by cheque if the GIRO transaction is not successful.)

4. Declaration, Authorisation and Consent (to be signed by the Claimant/Guardian) :

(a) I hereby declare that the statements and answers given in this form are true and complete to the best of my knowledge and belief, and further, that I have not made any false or fraudulent statement, suppressed or concealed any facts. (b) I hereby expressly authorise and consent to: (i) any hospital, medical practitioner, clinic, any medical source and any insurance office to disclose to Prudential Assurance Company Singapore (Pte) Limited ("Prudential") or its appointed third party service providers, all information relating to me or the dependent, including my/our personal particulars, my/our medical records, and any information required; and (ii) Prudential collecting, using and disclosing the information set out in sub-section (i), above to any of the following persons whether in Singapore or elsewhere: (1) Prudential's holding companies, branches, representative offices, subsidiaries, related corporations or affiliates;(2) any of Prudential's contractors or third party service providers; and (3) the Policyholder and its appointed intermediary, for the purposes of claims assessment, policy servicing, statistical analysis, investigation of Prudential's representatives and monitoring undesirable sales practices. (c) I understand and agree that a photocopy of this authorisation shall be as valid as the original.

Name and Signature of Patient/Guardian

Date

Part C (to be completed by Attending Doctor/Surgeon)

1. Name of Patient : _____

2. Admission date : _____ Discharge date : _____

3. Name of hospital : _____

4. Period of medical leave : From _____ To : _____

5. Primary diagnosis : _____ (ICD Code _____)

6. Date of first diagnosis : _____

7. Date of first consultation : _____

8. a) Date of surgery : _____

b) Type of surgical procedure : _____

Surgical Code : _____

c) If excision was performed, please indicate the measurements of the lesion/tumor _____

d) Were the above surgical procedures approached through the same incision/orifice? Yes No

e) Was surgery performed for cosmetic purposes? Yes No

9. a) What complaints did the patient present with when first consulted you? _____

b) How long had the patient been troubled by the symptoms prior to consulting you? _____

c) In your opinion, how long do you think the illness existed prior to your diagnosis? _____

10. Has the patient had any prior treatment for this condition? Yes No

If "Yes", state the date of treatment, name & address of doctor who treated the patient

11. Was the patient referred by another doctor? Yes No

If "Yes", please furnish the name and address of the referral doctor.

12. Was the above condition discovered during your investigation of his/her inability / difficulty in starting a family ? Yes No

13. Was the condition of patient due to:

a) congenital anomaly? Yes No

b) mental, emotional, psychological or psychiatric disorder? Yes No

c) dental/gum treatment or oral mucosal? Yes No

d) pregnancy, childbirth, sub-fertility or infertility? (Date of LMP _____) Yes No

Name of doctor : _____

Name & address of clinic : _____

Signature of doctor : _____

Date : _____