RafflesHealthInsurance
Your Specialist Health Insurer

HOSPITAL & SURGICAL CLAIM FORM
(Individual and Group Policies)

IMPORTANT NOTES: It is important to read the notes below before you complete the claim form.

PREPARING REQUIRED DOCUMENTS

Please complete this form in **FULL** and submit the following documents within 60 days of discharge from the hospital:

- Original Final Summary and Itemised Hospital Bills. (Photocopied / Interim / Certified True Copy / Duplicate bills are not acceptable)
- For Government Restructured Hospitals :Inpatient Discharge Summary / Day Surgery Discharge Form / Histology Report
- For Overseas Hospitals / Private Hospitals / Clinics: Attending Physician's Statement (refer Page 3)
- Please note that this form is **NOT** an acceptance of your claim.
- Please note that incomplete submission of documents may delay the processing of your claims.

SECTION 1: PARTICULARS OF INSURED

Name of Policyholder / Employer			Policy No.	Plan Type
Name of Insured Person / Employee			NRIC / Passport No.	Date of Birth (DD/MM/YYYY)
Gender ☐ F ☐ M	Marital Status ☐ S ☐ M	Occupation	Date Joined Company (for Group Policy) (DD/MM/YYYY)	Contact Nos. (Off) (Hp)
Address			Email Address	

SECTION 2: PARTICULARS OF PATIENT (To complete if Dependent) - *Child Dependent age above 18 years old must submit a copy of their Student Pass*

Name of Patient (if dependant of employee)			NRIC / BC / Passport No.	Date of Birth (DD/MM/YYYY)
Gender ☐ F ☐ M	Marital Status ☐ S ☐ M	Occupation	Effective Date of Insurance (DD/MM/YYYY)	Relationship of Dependant ☐ Spouse ☐ Child

SECTION 3: DETAILS OF ILLNESS OR INJURY

A. Hospitalisation due to Illness

Nature of Illness/Final Diagnosis

Describe Symptoms and date symptoms first appeared

Type of Operation performed (if applicable)

Date illness first treated/Date of first consultation (DD/MM/YYYY)	Name of doctor/hospital the patient first consulted for the illness

Is the illness job-related? ☐ No ☐ Yes

Is the illness due to pregnancy, miscarriage or fertility? ☐ No ☐ Yes

B. Hospitalisation due to Injury from Accident

Describe how it happened and state the extent of the injury (Please enclose a copy of the police report, if any.)

Date of Accident (DD/MM/YYYY)	Time of Accident (HH : MM)	Place of Accident

Is the injury/accident job-related? ☐ No ☐ Yes

Is it claimable under Workmen's Compensation? ☐ No ☐ Yes

SECTION 4: OTHER INFORMATION

(For Group Policy Only) Please select one for claim payment:

☐ Pay Employee : ☐ Cheque ☐ Giro (provide details below)

☐ Pay Employer : ☐ Cheque ☐ Giro (provide details below)

Details of bank account (COMPULSORY)

Name of A/C Holder .....

Bank & Branch .....

A/C No. .....

Are you making a claim from any other insurance companies?

☐ No ☐ Yes, please provide information below :

Name of insurance company .....

Type of Policy ..... Policy No .....

* Please submit a copy of the other insurance company's claim settlement letter or payment voucher

SECTION 5: DECLARATION & CONSENT

PERSONAL DATA NOTICE

1. I understand, acknowledge, agree and consent that Raffles Health Insurance Pte Ltd (**"RHI"**) or its representatives are permitted to :

   (a) collect, use, disclose and/or process my personal information set out in this form and any other personal information provided by me or from other sources such as employer, intermediaries, medical organisations, third party providers or agents (which may be sited outside of Singapore), other insurance companies (collectively the **"Personal Information"**) for the purpose(s) set out below; and/or

   (b) disclose and transfer such Personal Information to other sources such as other departments in RHI, employer, intermediaries, medical organisations, banks, CPF Board, reinsurers, third party service providers or agents (which may be sited outside of Singapore), other insurance companies, for the purpose(s) set out below :

   (c) **Purpose(s)**

   (i) processing, handling and/or dealing with my claims including the settlement of the claims and any necessary investigations relating to the claims;

   (ii) investigating the accident and/or my claims;

   (iii) carrying out and/or dealing with my instructions or responding to any enquiries by me;

   (iv) administering my claims (including the mailing of correspondence, statements, invoices, reports or notices to me, which could involve disclosure of certain personal data about me to bring about delivery of the same as well as on the external cover of envelopes / mail packages); and/or

   (v) complying with applicable law in administering, processing, handling and/or dealing with my claims.

2. I further acknowledge and consent that my Personal Information may be collected, used and/or disclosed by RHI for :

   (a) carrying out due diligence activities in accordance with legal or regulatory obligations or risk management procedures required by law or the Monetary Authority of Singapore (**"MAS"**) or implemented by RHI;

   (b) responding to requests for information from other insurance companies, MAS, General Insurance Association of Singapore (**"GIA"**), Life Insurance Association of Singapore (**"LIA"**) or other relevant government agency/authority (such as police).

DECLARATION & AUTHORISATION

1. I hereby declare that the information on this form and any documents attached to it is correct and complete and I have not withheld any information that could affect this claim.
2. I hereby authorise any hospital, physician or other person who has attended to me to furnish Raffles Health Insurance Pte Ltd or its representatives all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment, copies of all hospital or medical records.
3. I agree that a photocopy of this authorisation shall be considered as effective as the original.

X

_____

Signature & Name of Employee

Date:

X

_____

Signature & Name of Patient
(Employee to sign if patient below 21 years old)

Date:

X

_____

Signature Employer / Company Stamp

Date:

Attending Physician's Statement

(To be completed for patients seeking treatment at Overseas Hospitals / Private Hospitals / Clinics)

Name of Patient	Date of Birth	NRIC / Passport No	Gender ☐ F ☐ M

SECTION 1: Details of Illness / Injury

Final Diagnosis of illness or extent of injury

ICD Code ☐☐☐

What was the cause of the illness / injury?
(If due to an accident, please furnish date of accident)

When did the patient first consult you for this condition?

What was the patient's complaint or symptoms presented during the first consultation?

How long has the illness / symptoms been existing prior to consulting you?

Is the condition / treatment related to :	No	Yes	If '**Yes**', please elaborate:
a) Congenital Anomaly / Birth Defect / Genetic / Hereditary disorder?	☐	☐	
b) Dental / Gum Treatment / Oral Mucosal?	☐	☐	
c) Pregnancy / childbirth / abortion / miscarriage / birth control /infertility?	☐	☐	
d) Cosmetic / Aesthetic Treatment?	☐	☐	
e) Correction of eye refraction?	☐	☐	
f) Emotional / stress / psychiatric / psychological / sleep disorder?	☐	☐	
g) Attempted suicide / Self-inflicted Injury / Alcoholism / Drug Addiction?	☐	☐	
h) Natural / Physiological Menopause?	☐	☐	
i) Developmental Delay / Learning Disability	☐	☐	
j) STD, AIDS or infection by HIV?	☐	☐	
k) Human Papilloma Virus (HPV)?	☐	☐	

l) Has the patient been treated by other doctor(s) for this illness before consulting you? If 'Yes', please state when and the name of doctor, and name and address of clinic.

m) Was the patient referred by any of the above doctors? ☐ No ☐ Yes

n) Did the patient suffer similar or related conditions in the past? If 'Yes', please state when, nature of problem, name and address of attending doctor and dates of treatment.

SECTION 2: Details of Surgical Procedures & Treatment

Surgical operations performed on patient

Operation Codes*	**Type of operation**	**Tables***	**Date performed**

Where was the operation / surgical procedure(s) performed? ☐ Hospital ☐ Clinic

Were the surgical procedures approached through the same incision? ☐ Yes ☐ No

If excision was performed, please indicate the size / measurement of the lesion / tumour

Name of Surgeon

Name of Anesthetist

If no surgery was performed, was the admission for diagnostic purpose?

Please state the reason for admission and treatment and medication rendered during the admission.

Is the patient still under your care for the condition?

☐ No. Please state date of termination

☐ Yes. How long do you expect to continue?

When are you going to review the patient again?

If patient has been referred to another doctor for follow-up, please furnish name and address of doctor.

Is the condition likely to relapse or require long term care? ☐ Yes ☐ No

* For surgery done in Singapore based on Tables of Surgical Operation for Medisave scheme, 1 Jan 2014.

SECTION 3: Doctor's Certification

Declaration

I …….. the undersigned, do hereby declare that I was the doctor in attendance during the last illness of ……and that the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from the Company.

Name of Doctor	: _____	Signature	: _____
Name of Clinic/Hospital	: _____	Professional Qualification	: _____
Clinic / Hospital Stamp	: _____	Date	: _____