



Pre-Hospitalisation Form

Upon completion, please email this form to
BizBen@mhcasiagroup.com

Singapore Life Ltd.
c/o MHC Medical Network P/L 1
Commonwealth Lane
#02-13 Singapore 149544
Tel: **1 800 8800 880/+65 6305 4571**

Patient's Particulars					
Name of Patient		Policy No		NRIC/Fin	
Date of Birth		Gender	Male/ Female	Contact Details	

Section A – Consent and Authorisation (To be completed by Patient)

I hereby declare and agree to the following:

- This part must be signed by the patient's parent / legal guardian if patient is below 21 years old.
- I/We hereby authorise Singapore Life Ltd. ("Singlife") to request from any hospital, physician, person or organisation, all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records concerning the patient at any time and authorise the prior mentioned organisations to disclose all such information to Singlife. A photocopy of this authorisation shall be considered as effective and valid as the original.
- I understand that I am personally liable for any charges not covered under the policy.
- I/We consent to Singapore Life Ltd ("Singlife") (and Singlife related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s) and/or managing my/our relationship with Singlife.
- I/We also consent to Singlife (and Singlife related group of companies) transferring my/our personal data to Singlife (and Singlife related group of companies) and their respective third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.
- I/We have read and understood Singlife's Data Protection Notice which may be found at www.singlife.com/pdpa. Singlife's Data Protection Notice may be updated from time to time without notice. I/We am/are aware that I/we should visit your website regularly to ensure that I/we am/are well informed of the updates.

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Patient's Signature (NRIC/FIN) Date

Section B – Medical Information (To be completed by Doctor/ Surgeon)

1. Details of Admission

Hospital Name		Admission Date		Surgery Date	
Length of Stay (estimated)	Days	Surgical Procedure		TOSP Code and Table	

2. Condition Requiring Treatment

1st Consultation Date		Symptoms Presented		Duration	
Diagnosis and ICD 10				Diagnosis Date	

3. Medical History – Please complete if Patient has consulted any doctor(s)/ hospital(s) prior to consultation with you

Name & Address of Hospital		Diagnosis		1st Diagnosis Date	
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4. Cost Estimation

Surgeon's Fees	\$	Anesthetist's Fee	\$
Doctor's Attendance Fees	\$ () per visit x () Days	Room & Board	\$ () per day x () Days Ward Class:
Hospital Charges (estimated)	\$	Implants	\$ Type of implant:

5. Was Patient's condition due to or related to any of the following

Pre-existing conditions	Routine medical examinations/ Check-ups
Self-inflicted injury/ Work-related injury	Consequence of accidents
STDs/ Treatment or test or conditions in connection with HIV / AIDS	Abuse of alcohol/ Drug addiction or abuse
Congenital conditions/ Birth defects/ Hereditary conditions	Pregnancy/ Abortion/ Childbirth/ Infertility/ Subfertility
Dental/ Gum related condition	Aesthetic / Cosmetic reason for surgery
Mental, Psychological or Emotional disorder	Experimental/ Pioneering medical and surgical techniques

If you have circled any of the condition(s), please give full detail

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Doctor's/ Surgeon's Signature

.....
Date

.....
Hospital/ Clinic Stamp