GROUP MEDICAL INSURANCE CLAIM FORM

Singapore Life Ltd.
Group Life & Health Claims
4 Shenton Way, #01-01 SGX Centre 2
Singapore 068807
Tel: 6827 8030
Company Registration No. 196842419 9K

SECTION 1 : TO BE COMPLETED BY POLICYHOLDER OR INSURED PERSON

Help us To Serve YOU Better – Contact & Payment Details			
Policy No:	Name of Company:		
Best way to contact you Please Tick ☑ (at least one or both)	☐ Mobile:	☐ Email:	Address of Employee:
Your Bank Details for Direct Credit	Bank Name:	Branch Code:	Bank A/C No:
*Note : Payment will not be made to employee unless prior arrangements was made by your employer with Singapore Life Ltd.			
Type of Claim – Please Tick ☑ (One Claim Per Member)	☐ Inpatient	☐ Outpatient	

About YOU – To Be Completed by Employee				
Name:		NRIC:	Employee ID:	
Gender: ☐ M ☐ F Please Tick	Date of Birth:	Date of Employment:	Occupation:	Nationality:

About YOUR Dependant – Applicable For Dependant Claim ONLY			
Name:		NRIC:	Date of Birth:
Gender: ☐ M ☐ F Please Tick	Nationality:	Relationship to Employee: Please Tick ☐ Child / ☐ Spouse	Occupation:

Please Tick ☐ **Illness**	Please Tick ☐ **Accident**
Nature of Illness:	Accident Date & Time:
	Brief Description of Accident:
Nature of Operation (**Applicable if there is surgery performed**):	
Date of FIRST Treatment:	
Name of Referring Doctor (**NOT APPLICABLE for GP Visit**):	
Were you / your dependant hospitalised as a result of an illness or accident? ☐ Yes ☐ No	
Date of Admission:	Date of Discharge:

CONSENT & AUTHORISATION

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/We declare that the statements and answers stated are true and complete to the best of my/our knowledge and belief.
I/We declare and undertake that I/we have submitted the actual bills and receipts (including electronic/digital copies) issued by the medical institution.
I/We understand that Singlife has the right to:

- Ask for originals/certified true copies of the bills and receipts, or contact the medical institution directly, to confirm that the bills and receipts are original.
- Reject claims, recover amounts paid or impose additional charges, if the claim is false or where there are multiple claims made.

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 Policy which may be found at www.singlife.com/pdpa. Singlife's Data Protection Policy 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.

____________ Signature of Employee	____________ Signature of Patient (For Dependant)	____________ Date

For Your EMPLOYER (NOT APPLICABLE FOR NAMED BASIS COVER)		
Effective Date of Coverage:	Date of Employment:	Plan:
Company Name & Stamp:	Signature of Employer:	Date of Signature:

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SECTION 2: MEDICAL REPORT (TO BE COMPLETED BY ATTENDING PHYSICIAN / SURGEON)

For admission to Private Hospital or Hospital outside Singapore, claimant must arrange to have this section completed by the Attending Physician when submitting a claim.

Patient Information		
Policy No:	Name of Company:	
Name of Patient:	NRIC/Passport No:	Admission Period:

Nature of Illness	Nature of Treatment / Surgery
01) Final Diagnosis (Based on ICD 10) of illness or extend of Injury DRG Code ☐☐☐☐ ICD Code ☐☐☐☐ ICD Code ☐☐☐☐ Date of Diagnosis:__________	05) Date of surgical procedure or treatment rendered : __________ Operation Code ☐☐☐☐☐☐ Operation Table ☐☐
02) Given the aetiology of the condition, please state the estimated date of such condition would be in existence.	06) Describe the surgical procedure or treatment rendered. If no surgery was performed, please state treatment / medication given
03) What is the cause of illness / injury?	07) If excision was performed, please indicate the size of the lesion / tumor. (Please attach a copy of the Histology Report)
04) What is the anatomy of this illness?	08) Name of a) Physician __________ b) Surgeon __________ c) Anesthetist __________

09) Is the condition/treatment related to:		Yes	If "Yes", please elaborate.	No
a) Pregnancy or childbirth	a)	☐	__________	☐
b) Abortion or Miscarriage	b)	☐	__________	☐
c) Infertility or Sub-fertility Condition	c)	☐	__________	☐
d) Congenital Anomaly	d)	☐	__________	☐
e) Genetic or Chromosomal Disorder	e)	☐	__________	☐
f) Mental or Psychiatric Condition	f)	☐	__________	☐
g) Cosmetic Surgery	g)	☐	__________	☐
h) Is the surgery for correction of short sightedness?	h)	☐	__________	☐
i) Is the surgery for dental purposes?	i)	☐	__________	☐

Medical History	
10) Please provide the name and address of referring doctor if patient was referred to you.	15) If there is no symptoms presented, what has prompted the patient to see you?
11) When did the patient first consult you for this condition?	16) Please specify the approximate date of discovery of the illness or injury
12) Nature and Date of Treatment rendered	17) How long has the illness / injury existed prior to consulting you?
13) What were the symptoms/complaints prior to consulting you?	18) Has the patient ever had the same or similar condition / symptom? ☐ Yes ☐ No ☐ Not to my knowledge
14) Please indicate the nature of Symptoms and date Symptoms first started	19) Doctors previously consulted by the patient for the above condition. Name of Doctors: __________ First Consultation:__________ Name of Clinic: __________ Address: __________
20) Is the patient still under your care for this condition? ☐ Yes ☐ No If Yes, please state the estimated duration that patient needs to follow up with you.	If No, please give termination date of service and furnish name and address of doctor if the patient has been referred to another doctor for follow up

____
Signature of Physician / Surgeon

____
Date

____
Name / Designation

____
Name and Address of Clinic / Hospital & Stamp