REQUEST FOR LETTER OF GUARANTEE

All details in this form are to be duly completed and signed by both the doctor and the insured member.
For admission to Private Hospital, Page 2 of this form is to be completed by the Attending Physician.
For admission to Government/Restructured Hospital, please provide relevant documents such as Hospital Financial Counselling/Admission Forms.
Please submit this form prior to the surgery or procedure, together with any full medical report(s) or laboratory test result(s) to:

- Fax : 6715 9429
- Email : tmlog@ihp.com.sg
- Hotline : 6715 6403

Particulars of Insured Member

Name of Employee : ______________________________ **NRIC / Passport No:** _________________

Name of Patient : ______________________________ **NRIC / Passport No:** _________________ **Relationship:** ____________

Name of Employer : ______________________________ **Policy No :** _________________

Date of Employment: ______________________________ **Contact No :** _________________

Email Address : ______________________________

Declaration & Authorisation

1. I hereby authorise, agree and consent to:

   a) Insurer and Integrated Health Plans Pte Ltd to request from any hospital, physician, person or organisation, all information with respect to any illness, injury, medical history, and copies of all hospital or medical records concerning myself or dependants at any time and authorise the prior mentioned organisations to disclose all such information to Insurer and Integrated Health Plans Pte Ltd.

   b) Insurer and Integrated Health Plans Pte Ltd collecting, using, and/or disclosing my personal data for the processing of pre-authorisation and such other purposes ancillary or related to the administering of my insurance coverage and claims adjudication.

2. I agree that Insurer and Integrated Health Plans Pte Ltd and my Employer reserve the right to recover any outstanding amount should my total medical expenses exceed the policy coverage and/or is not covered under the policy.

3. I hereby declare that all the information, above statements and answers including any attachments related to it are true and complete. I have not withheld any material fact from Insurer, Integrated Health Plans Pte Ltd and my Employer.

4. This declaration and authorization shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not our claim is accepted by Insurer and Integrated Health Plans Pte Ltd. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

Signature of Employee: ______________________________

Signature of Patient / Guardian if patient is below 21 years old: _________________________

Date: ___________________

Disclaimer
This request for letter of guarantee does not guarantee the acceptance, application or availability of insurance. The content of this form has been compiled by Integrated Health Plans Pte Ltd and is subject to the terms, conditions and exclusions of the regulated insurer's policy wording which may change from time to time. Refer to the relevant policy document for complete and most up to date details. Integrated Health Plans Pte Ltd will not be held liable for the contents of this form, its existence or any representations made in its connection.

To be completed by Attending Doctor/Surgeon

For admission to Private Hospital, patient must arrange to have this section completed by the Attending Physician.
For admission to Government/Restructured Hospital, please provide relevant documents such as Hospital Financial Counselling/Admission Forms.

1. Particulars of Attending Doctor/Surgeon

Doctor/Surgeon: ______________________________ Referring Doctor: __________________________________

Clinic Name: __________________________________ Clinic Address: ____________________________________

2. Details of Surgery/Procedure

Hospital Name: ________________________________ Admission Date: ___________________________________

Date of Surgery: ________________________________ Surgical Code: _____________________________________

Surgical Procedure: (Surgical Code)____________________ Estimated Length of Stay: ___________________________

3. Condition Requiring Treatment

Symptoms: ____________________________________ Symptoms Apparent from: __________________________

Final Diagnosis of Illness or Extent of Injury: ____

Diagnosis Date: __________________________________ First Consultation Date: ____________________________

ICD 10 Code: __________________________________

a) Has this or any similar condition existed previously? ☐ NO ☐ YES
If yes, please attach details and proceed to next question

b) Has the patient had any prior treatment for this condition? ☐ NO ☐ YES
If yes, please state date of treatment, name and address of doctor who treated the patient

----

4. Is the condition of patient due to or related to:

- Congenital anomaly/Genetic/Chromosomal Disorder? ☐ NO ☐ YES
- Psychological, mental or emotional disorder? ☐ NO ☐ YES
- Dental/gum treatment or oral mucosal? ☐ NO ☐ YES
- Pregnancy, childbirth, sub-fertility or infertility? (Date of last menstruation ________) ☐ NO ☐ YES
- Self-inflicted injury, drug addition, alcoholism ☐ NO ☐ YES

5. Admit as: ☐ IN-PATIENT ☐ DAY-SURGERY

6. Cost Estimation

(A) Surgeon's Fee : SGD________________________ (D) Room & Board: SGD_____ /day X ____ = ________

(B) Anesthetists Fee : SGD_________________________ (E) Ward Class: _________________________________

(C) Doctor's Attendance Fee : SGD______/visit X ____ = _____________

(F) Hospital Charges *(approx)*:_____________________

Total Estimated Bill (A + B + C + D + F) : SGD ___________________________

Doctor/ Surgeon's Signature : ___________________________________ **Date** : ____________________

Clinic/ Hospital Stamp : ____________________________