Request for Guarantee of Payment

Please submit this form prior to the surgery or procedure, together with any full medical report(s) or laboratory test result(s) to:

- Fax: 6564 6038
- Email: cignaqueries@alliancemedinet.com
- Hotline: 6664 0240

Particulars of Insured Member

Name of Employee* : _____ NRIC : _____
*(to complete if patient is a dependant of the employee who is below 18 years of age)

Name of Patient : _____ NRIC : _____

Name of Employer : _____ Membership ID : _____

Email Address : _____ Contact No : _____

Declaration & Authorisation

1. I confirm I am the patient/patient's parent/patient's legal guardian* (delete where applicable) and wish to claim under the Policy.
2. I hereby authorise, agree and consent to:
   a) Cigna Europe Insurance Company S.A.-N.V. Singapore Branch ("Cigna Singapore") and Alliance Medinet Pte. Ltd. (a subsidiary of Alliance Healthcare Group Pte. Ltd.) ("Alliance") to request from any relevant medical source (including doctors, hospitals, clinics, medical examiners, laboratories and diagnostics centres) (collectively known as, "Medical Source") , all information with respect to any illness, injury, medical history, prescriptions, consultation, or treatment and copies of all hospital or medical records concerning myself or the above-mentioned patient at any time; and authorise the Medical Source to disclose all such information to Cigna Singapore and its authorised representative (including its appointed administrator, Alliance) for the purpose of processing this request for letter of guarantee and other relevant administrative purposes in administering the Policy; and
   b) Cigna Singapore and its related corporations (collectively, the "Companies"), as well as the Companies' authorised service providers (including its appointed administrator, Alliance) and relevant third parties, collecting, using and/or disclosing my personal data (including the above-mentioned patient's personal data) for purposes reasonably required by the Companies to process this request for letter of guarantee for pre-authorisation purposes and other relevant administrative purposes in administering the Policy; as well as such other purposes as described in Cigna Singapore's Personal Data Protection Policy. Cigna Singapore's Personal Data Protection Policy is accessible from Cigna Singapore's website, which I confirm I have read and understood.
3. I agree that Cigna Singapore (including Alliance, on behalf of Cigna Singapore) reserve the right to recover any outstanding amount from me should my total medical expenses exceed the policy coverage and/or is not covered under the policy.
4. I hereby declare that all the information provided in this form including any attachments related to it are true and complete in every detail; and I have not withheld any material fact from Cigna Singapore (including its appointed administrator, Alliance).
5. This declaration and authorisation shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not our claim is accepted by Cigna Singapore. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

_____
Signature of Patient

_____
Signature of Employee*
(in the capacity as parent or legal guardian if patient is dependant of the employee who is below 18 years of age)

ALLIANCE MEDINET

Cigna

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

1. Particulars of Attending Doctor

Attending Doctor : _____ 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? ☐ Yes ☐ No
If yes, please attach details and proceed to next question

b) Has the patient had any prior treatment for this condition? ☐ Yes ☐ No
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:

a) Pregnancy or childbirth ☐ Yes ☐ No

b) Infertility or Sub-fertility Condition ☐ Yes ☐ No

c) Congenital Anomaly ☐ Yes ☐ No

d) Genetic or Chromosomal Disorder ☐ Yes ☐ No

e) Mental, Nervous, Emotional or Psychiatric Disorder ☐ Yes ☐ No

f) Cosmetic Surgery ☐ Yes ☐ No

g) Is the surgery for correction of short sightedness? ☐ Yes ☐ No

h) Abortion/Miscarriage/Impotency Sterilisation (If related to miscarriage, was it due to accident)? ☐ Yes ☐ No

i) Sexually Transmitted Disease/AIDS and Illness or Disease related to HIV ☐ Yes ☐ No

j) Self-inflicted injury / Drug Addition / Alcoholism ☐ Yes ☐ No

k) Sleep Apnea / Obesity / Weight Reduction / Improvement ☐ Yes ☐ No

5. Is the condition of patient due to or related to: ☐ IN-PATIENT ☐ DAY-SURGERY

4. Cost Estimation

(A) Surgeon's Fee : SGD_____

(B) Anesthetists Fee : SGD_____

(C) Doctor's Attendance Fee : SGD_____ /visit X _____ = _____

(D) Room & Board : SGD_____ /day X _____ = _____

(E) Ward Class : _____

(F) Hospital Charges (approx) : _____

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

Attending Doctor's Signature : _____

Date : _____

Clinic/Hospital Stamp : _____

Disclaimer

This request for Guarantee of Payment does not guarantee the acceptance, application or availability of insurance.