

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)