GLOBALIS

Claim Form (Medical)

SAFE MERIDIAN

Great Eastern
A member of the OCBC Group

Let's make this fast.

To ensure there is no delay in processing your claim, remember we need:

- ✓ Your signature at the end of this Claim Form.
- ✓ All original itemized invoices, prescriptions and reports attached.
- ✓ A referral letter if you're lodging a claim for physiotherapy services.
- ✓ A separate claim form for each member with claims.

Once you've lodged your Claim, you can track its status on MemberOnline, or drop us an email at any time to request an update. If we need additional information, we'll let you know.

Don't forget, you can submit claims online using MemberOnline for faster processing, and you won't need to complete this form.

Submitting your claim:

You're welcome to send us claims by:

- **Mail:**
  Safe Meridian Claim team
  10 Chang Charn Road #04-01
  Singapore 159639
- **Email** *(size limit 8MB)*:
  Send attachments to
  myclaims@safemeridian.com
- **Using your MemberOnline secure portal**

① Policy & Patient Information

Required for all claims

Name of Policyholder:

Name of Patient (if different): Member Number:

Passport No./National ID: Date of Birth (dd/mm/yyyy):

Email address: Phone (+country code):

Do you or the patient have any other insurance policies that cover this treatment? ☐ Yes ☐ No

Have you received (or will you receive) compensation from any third party for this treatment? ☐ Yes ☐ No

If 'yes' to either question above, please provide us the name of the insurer or third party and amount you will or have been compensated (if known):

② Medical Details

Required for all claims

Please answer as accurately as possible. If there is insufficient space, provide details in separate pages and attach them.

1. What medical condition was the patient suffering from, and what treatment was provided?

2. What was the nature of the condition? ☐ Acute (not an ongoing condition) ☐ Chronic (periodically reoccurring) ☐ Accident Related ☐ Check-up

3. What was your doctor's diagnosis?

4. What symptoms are/were you experiencing?

5. Duration of the illness/condition: From (dd/mm/yyyy): to (dd/mm/yyyy):

6. When did you first see a doctor for this condition?

7. If further treatments are planned, let us know what they are:

8. Name & address of your doctor:

9. Currency of claim(s):

10. Amount Claimed:

11. Is this claim connected to any work-related accident or to your employment in any way? ☐ Yes ☐ No

If 'Yes', please provide details of the accident and injuries sustained:

Hospitalization/Inpatient

Hospitalization claims only

Name of Hospital/Day Surgery Facility:

Address:	Country:
Contact Person:	Email address:
Phone (+country code):	Fax Number (+country code):
Admission Date (dd/mm/yyyy):	Discharge Date (dd/mm/yyyy):
Type of Hospital Room:	Daily Room Rate (& currency):

* If the patient was admitted into hospital and will not be submitting a claim for the hospitalization, if they are entitled to a Hospital Cash Benefit a confirmation of admission from the hospital noting the full cost incurred and reason for admission must be attached in order for the claim to be paid. It must be on the hospital letterhead or bear the hospital stamp to be accepted.

Physiotherapy

Physiotherapy claims only

Name of referring doctor:	Name of Physiotherapist:
Phone (+country code):	No. of Sessions Required:
Address of referring doctor:	

*Please attach a referral letter in order for the claim to be considered.

Maternity/Pregnancy related treatments

Maternity related claims only

What is the estimated date of delivery? (dd/mm/yyyy)

Is the pregnancy the result of assisted conception treatment(s)? ☐ Yes ☐ No

③ Claim Details

Required for all claims

List below the details of each invoice for which you are seeking reimbursement. If there is insufficient space, please provide details in separate sheets. Charges without a declared medical condition cannot be reimbursed.

Date of Service	**Description of Treatment/Expenses** (e.g. Pre or post hospital treatment, GP, Specialist, Dental, Optical, Wellness)	Diagnosis/Medical Condition	Currency & Amount Paid by You

④ Questions for your Doctor/Dentist

Required for claims above $500 only

This section must be completed by your doctor or dentist if you're submitting a claim for more than $500.

As an alternative, we can accept an email or letter from your doctor providing the information below. Any email from your doctor should include an email signature and must be sent from an email account of the Hospital or Clinic. We cannot accept such emails from Gmail accounts or similar. Keep in mind your Policy doesn't cover fees for reports or form completion.

1. What is/was the nature of the condition? ☐ Acute ☐ Chronic ☐ Congenital ☐ Accident/Emergency treatment
2. What condition, symptoms, or injury required treatment? (for dental work, please include the tooth numbers involved)
3. What was your diagnosis (or ICD10)? ☐ Final ☐ Working
4. What surgery or procedure was undertaken (if any)?
5. When did you first see the patient for this or any related condition? (dd/mm/yyyy)
6. What date did the patient report first experiencing symptoms related to this condition? (dd/mm/yyyy)
7. Is there any underlying cause(s) of the condition being treated? If so, please explain:
8. Has the patient previously suffered from a similar or related condition? ☐ Yes ☐ No

   If yes, please provide: i) Date(s) of treatment (dd/mm/yyyy):

   ii) Details of treatment provided:
9. Has the patient been treated for this or any related condition elsewhere? ☐ Yes ☐ No

   If 'Yes' please provide details (dates of treatment, provider names):

10. Given the aetiology of the condition, how long do you think it has been present? (dd/mm/yyyy)

11. Was the patient referred to you by another doctor? ☐ Yes ☐ No

If 'Yes' please provide their name and contact details:

12. What Treatment Plan have you recommended going forwards (e.g. drugs prescribed, return visits requested, etc.)?

13. Is the patient suffering from any other conditions? If yes, please provide details:

Doctor/Dentist Declaration

I declare I am the treating doctor/dentist for the patient named in this claim and that the details provided in this Section 4 are accurate and complete.

Name of doctor/dentist:	Phone:
Email address:	Official stamp:
Name and address of clinic/facility:	
Doctor/Dentist's Signature:	Date Signed (dd/mm/yyyy):

⑤ Bank Account Details

Required for all claims

Please provide your Bank Account detail below. If we're not able to transfer payment in the currency requested, we'll reimburse you in the currency of your Policy.

Currency in which you would like to be reimbursed:

Account Name:			
Account Number:		IBAN*:	
Bank Name:		BIC/Swift Code:	
Bank Code:		Branch Code:	
Branch Address:			

*IBAN is required if your bank is within the EU or if your country requires an IBAN (e.g. Qatar, Saudi Arabia, Turkey).

⑥ Declaration & Authorization

Required for all claims

Please read the following carefully and sign below if you have understood and accepted it:

1. I confirm I have read, understood, agreed, and consented to Safe Meridian:
   - collecting, using, processing, and/or disclosing my personal data;
   - collecting personal data about me from sources other than myself and using, processing, and/or disclosing the same; and
   - disclosing and/or transferring my personal data to participating Insurers, claim administrators, assistance companies, third-party service providers or vendors, and to Safe Meridian professional advisors, wherever they are sited, for the purposes stated in Safe Meridian's Data Privacy Policy (which may be viewed at https://www.safemeridian.com).
2. If I have declared any personal data relating to other individuals, I confirm I have informed them of Safe Meridian's Data Privacy Policy, and obtained their consent prior to acting on their behalf and allowing for the collection, use, disclosure, and transfer of their personal data in accordance with Safe Meridian's Data Privacy Policy.
3. I declare that, to the best of my knowledge, all information supplied in this claim form is true, accurate, and complete.
4. I understand and agree that should I make any false, fraudulent or intentionally exaggerated claims, or withhold material facts whatsoever in respect of this claim, the policy will be cancelled without refund of the premiums already paid, and I shall forfeit all rights to recover therein.
5. I authorize any hospital, healthcare provider, and/or doctor who has ever attended or treated me, to provide Safe Meridian, the Insurer, or their appointed authorized representatives, with any and all information and medical records relating to any illness or injury, as may be necessary to access this claim.
6. I authorize ____ to act for and on my behalf in relation to the administration of this claim, which may include the disclosure of sensitive personal information.
7. I agree that a photocopy, facsimile or scan of this authorization shall be considered as effective and valid as the original.

____

Name of Patient
(or parent/guardian if patient is under 18 years of age)

____

Signature of Patient
(or parent/guardian if patient is under 18 years of age)

____

Date Signed (dd/mm/yyyy)