



Please note...

Your Pre-Authorization request should be submitted and received by us 5 to 10 days prior to the scheduled treatment. The earlier the better helps in case we need to obtain additional information with your doctor.

You only need to complete this Form for the treatments and services that require Pre-Authorization (see your Member Guide for details). If Pre-Authorization is not obtained for such treatments, benefits may be reduced or declined.

Emergency Admissions: If it is not possible to request Pre-Authorization because of an emergency, we must still be contacted within 24 hours of admission. If you're not able to contact us yourself, a family member or your treatment doctor or hospital can do so.

Do not delay treatment: You should never delay treatment your doctor considers urgent while waiting for our response to your Pre-Authorization request. We will not be responsible for any complication that may arise from such a decision.

Remember that failure to complete this form fully or to provide us with all relevant information may delay our response. If we need any additional information, we'll let you know.

Submitting your Pre-Authorization Request:

You're welcome to send it:

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

① Patient & Contact Information

To be completed by you

Name of Policyholder:

Name of Patient (if different):

Member Number:

Passport No./National ID:

Date of Birth (dd/mm/yyyy):

Contact Person (who we should contact regarding this Pre-Authorization request)

Name:

Relationship to patient (e.g. mother, uncle):

Email address:

Mobile Phone (+country code):

Do you or the patient have any other insurance policies that cover this treatment?

Yes No

Have you received (or might 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):

Is this claim connected to a work-related accident or to your employment in any way?

Yes No

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

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

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.	

Maternity/Pregnancy related treatments	Maternity related claims only
First day of the last menstrual period? (dd/mm/yyyy)	Estimated date of delivery? (dd/mm/yyyy)
Is the birth of a single baby expected? <input type="checkbox"/> Yes <input type="checkbox"/> No	Delivery method? <input type="checkbox"/> Normal <input type="checkbox"/> Caesarean
Is the pregnancy the result of assisted conception treatment(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide details:	

③ Expected Treatment Costs To be completed by your doctor, hospital or clinic

This section must be completed in by the doctor responsible for the patient's treatment, or by the hospital or clinic involved.
As an alternative, if they have provided you a formal cost estimate in writing which is on their letterhead and provides us all of the information requested below, you can ignore this section and just send the cost estimate to us together with this form.

Estimated Treatment Costs:	
Proposed admission date (dd/mm/yyyy):	Estimated length of stay: <input type="checkbox"/> nights(s) <input type="checkbox"/> day(s)
Is a fixed charge or package rate being offered? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, what is the package rate (and currency):	
If No, please complete the section below:	
Surgeon's fee:	Type of Hospital Room:
Anaesthetist's fee:	Daily Room Rate:
Operating theatre cost:	Other charges:
Total estimated cost:	

Healthcare Facility Information:	
Name of Facility:	Type of Facility: <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic
Address:	Country:
Contact Person:	Email Address:
Telephone Number (+ country code):	Fax Number (+ country code):

④ Doctor/Dentist Declaration

To be completed by your doctor

I declare I am the treating doctor/dentist for the patient named in Section 1 above, and that the details provided in this document are accurate and complete. I understand the Insurer will, if necessary, request a copy of my medical records for this patient.

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 Declaration & Authorization

To be completed by you

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

- 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>).
- 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.
- I declare that, to the best of my knowledge, all information supplied in this claim form is true, accurate, and complete.
- 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.
- 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, including copies of my doctor's original medical records, as may be necessary to access this claim.
- 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.
- 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)

Underwritten by: PT Great Eastern General Insurance Indonesia
A member of the OCBC Group
Registered and supervised by the Financial Services Authority (OJK)
MidPlaza 2, 23rd Floor, Jl. Jend. Sudirman Kav. 10, Jakarta, 10220
Indonesia

Arranged by: Safe Meridian Pte. Ltd.
Singapore Company Registration No. 201541480K
8 Cross Street, #28-01 Manulife Tower, Singapore 048424
Tel: +65 6692 9151 • Website: <https://www.safemeridian.com>



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