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CLAIM FORM - MEDICAL INSURANCE

Agency: ______________________ Policy No.: ______________________

Name of Policyholder: ______________________ [Plan: Room & Board Entitlement]

PARTICULARS OF POLICYHOLDER

Name of Policyholder:	
Address:	Postal Code ( )
Contact Person:	
Email:	Contact No.: (Office) (Mobile)

PARTICULARS OF CLAIMANT

Name of Claimant:		
NRIC / Fin No.:	Date of Birth:	Gender: ☐ Male ☐ Female
Contact No.:	Date of Employment:	Occupation:

DETAILS OF ILLNESS / INJURY

Please state exactly what happened:

____

____

State nature of illness / injury:

____

____

Date of Accident / Date symptoms first commenced: ______________________

Date condition was first treated: ______________________

Is injury work related: ☐ Yes ☐ No

Name and address of attending physician:

____

____

Has the insured person ever seen a doctor or been treated for any similar condition in the past? ☐ Yes ☐ No

If yes, please state date of previous treatment and name and address of attending doctor for previous treatment:

____

____

Have you claimed or do you intend to claim from any other insurer for this illness / injury? ☐ Yes ☐ No

If yes, please state: ______________________

Name of Insurer(s): ______________________ Policy Number(s): ______________________

Amount of compensation: ______________________

Do you have any other medical insurance with other insurer? ☐ Yes ☐ No

If yes, please state:

Name of the insurer(s): ____________ Policy number(s): ____________ Commencement date(s): ____________

PAYMENTS DETAILS

Cheque payee name (as shown in the bank account): ____________

(A letter of Authorisation is required if payee is not employer / insured employee)

PERSONAL DATA COLLECTION STATEMENT

To evaluate, process and administer this application or transaction, it is necessarily for us to collect, use, disclose and / or process your personal data or personal information about you. Such personal data includes information collected in this form, or in any document provided, or to be provided to us by you or processed by us, or from other sources.

A. Purpose of Collection

The personal data belonging to you and your insured/s may be collected, used and disclosed for the purposes of:

1. carrying out identity checks;
2. deciding whether to insure or continue to insure you and your insured persons;
3. providing advice for product recommendation based on your profile;
4. processing any claims under your policy, including the settlement of claims and any necessary investigations relating to the claims;
5. communicating on any matters relating to the services and / or products which you are entitled to under this policy;
6. respond to your inquiries or instructions and providing ongoing services, under your policy;
7. make or obtain payments and recovering any debt owed to us;
8. detecting and preventing fraud, unlawful or improper activities;
9. conducting market research and statistical analysis;
10. coaching employees for customer service quality assurance;
11. reinsuring risks and for reinsurance administration; and
12. complying with all applicable laws, including reporting to regulatory and industry entities.

B. Disclosure of Data

The personal data belonging to you and your insured/s may be disclosed for the purposes set out in Section A above to the parties below:

1. Third party service vendors, suppliers, agents, reinsurers, or intermediaries;
2. Medical Professionals and Institutions;
3. Local or overseas service third party vendors that provide us with services such as printing, mail distribution, data storage, data entry, marketing and research, disaster recovery or emergency assistance services;
4. Debt collection agencies;
5. Dispute resolution parties;
6. Parties that assist us to investigate, administer and adjudicate claims;
7. Financial institutions;
8. Credit reference agencies;
9. Industry associations; and
10. To any regulatory, government and statutory body to comply with applicable, laws or regulation or upon their valid request.

C. Personal Data Access and Amendments

You can request access to your personal data collected by us, and to make any corrections to your personal data so as to keep it updated. We may charge you a reasonable fee for providing you with the service.

D. Withdrawal Option of the collection and use of your personal data

You may make your request to withdraw your consent, access or correct your personal data by writing to: The Data Protection Officer, EQ Insurance, 5 Maxwell Road, #17-00 Tower Block, MND Complex, Singapore 069110. Alternatively, you can email to dpo@eqinsurance.com.sg.

Neither EQ Insurance nor any of its employees shall be liable for any loss or damage suffered by you or any user as a result of any disclosure of any personal data which you have consented to us and / or any of its employees disclosing.

Altering on this "Personal data collection statement" is strictly prohibited. Any attempt to do so will be of no effect.

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DECLARATION BY POLICYHOLDER / CLAIMANT

We / I declare that I have complied with the conditions and warranties (if any) of the Policy and in no manner deliberately caused the said loss or damages sought unjustly to benefit by an fraud or willful representation and that the information given on this form is true and correct to the best of my knowledge and belief.

____
Claimant's Signature / Date

____
Policyholder's Signature / Date
(Affix company stamp, if applicable)

Name of Claimant : ____________________

Date : ____________________

EQ Insurance Company Limited
5 Maxwell Road #17-00 Tower Block MND Complex Singapore 069110
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reg no. 1978-00490-N

A Member of Citystate

ATTENDING PHYSICIAN STATEMENT (TO BE COMPLETED BY ATTENDING DOCTOR / SURGEON)

Medical Certification of treatment to be fully completed by attending surgeon / physician. If treatment is sought in Private Hospital or Hospital outside Singapore, please arrange with your attending doctor to complete this form. You must bear the fee charged (if any) for completion of this form.
We reserve our rights to request for claimant to submit medical reports from other Hospital(s), if necessary.

Patients full name:

NRIC / PP / BC No.: | Date of Birth:

Name of Hospital admitted:

Date admitted: | Date discharged:

Have you seen this patient prior to the above said admission? ☐ Yes ☐ No

If yes, please state the date of the first consultation.

Please indicate the diagnosis of all the conditions treated and give a description of the symptoms of illness or injury:

What was the cause(s) of the injury / illness?

Has the patient ever had the same or any similar condition? ☐ Yes ☐ No

If yes, please state when and describe.

Date of first consultation: | Please give date of previous treatment:

Please give the names and address of the doctor who treated the patient previously:

Is the surgery / treatment for cosmetic reasons? ☐ Yes ☐ No

Is this an elective treatment / surgery? ☐ Yes ☐ No

Was the treatment provided to the patient related to the conditions stated below ☐ Yes ☐ No (If yes, please tick the relevant box)

- ☐ Congenital anomaly
- ☐ Self inflicted injuries or alcoholic or drug addiction
- ☐ Mental / Psychiatric disorder
- ☐ Pregnancy, infertility or childbirth
- ☐ Condition arising directly / indirectly from AIDs, any AIDs related disease or any sexually transmitted disease

Type of operation / surgical procedures performed

a. Date performed: ______________________

b. Type of operation / surgical procedures: ______________________

Is this patient suffering from any other medical condition? ☐ Yes ☐ No

If yes,

i. please state all the other medical condition(s).

ii. kindly advise if the patient was prescribed with any medications to treat his / her medical condition(s)?

Is there any other information, professional or otherwise that you consider should be made known to us?

Please advise period of medical leave given: | Is the patient still under your care for this condition?

____
Signature of Surgeon / Physician

____
Name, address and qualification of Surgeon / Physician

Date: ______________________