# Foreign Worker Medical Insurance Claim Form

| Policy No. | | Intermediary | |
|---|---|---|---|

Important Notice

1. This form is issued without admission of liability and must be completed and returned after completion of treatment.
2. You may be required at a later date to request the attending physician to complete the Medical Report (overleaf ).
3. The completion of the Medical Report will be at the policyholder's expense.

## The Insured

| | | | | | |
|---|---|---|---|---|---|
| 1. Name of Insured | | | | NRIC / PP No. | |
| Residential Address | | | | | |
| Residential Tel No. | | Mobile No. | | Business Tel No. | |
| 2. Person Under Treatment | | | | | |
| Business / Occupation | | | | Date of Birth | |
| 3. (a) Nature of illness / injury | | | | | |
| (b) When did it start? | | | | | |
| 4. Name and address of the Doctor whom you first consulted | | | | | |
| 5. Name and address of your usual Doctor | | | | | |
| 6. Have you ever suffered from the illness/injury in respect of which you are claiming? | | | | | |
| 7. Have you previously claimed or received compensation under an Accident or Hospitalisation Policy? If yes, give particulars | | | | ☐ Yes ☐ No | |
| 8. (a) Are you also insured under an employer's group medical plan or any other medical plan? (b) If yes, please provide the names of Company/Insurer and amount you are entitled to claim | | | | ☐ Yes ☐ No | |

## Declaration

I/We claim the amount of $_____being expenses incurred by me/us for treatment in accordance with the particulars above and receipted bills attached. I/We understand that all information and supporting documents may be subject to review by Etiqa and Etiqa shall reserves all rights to reject any claims, recover any and all amounts, or to impose additional charges if for any reason any claim is found to be fraudulent. Etiqa shall also reserve the right to pursue any actions at law or in equity that it deems appropriate in dealing with such fraudulent activity.

I/We declare that the bills submitted are indeed what were received from the public healthcare institutions. Etiqa reserves the rights to request for the original bills or certified true copies and to contact the public healthcare institutions directly if needed for validation of the bill authenticity.

I/We hereby declare that the foregoing particulars are true and correct, that no information has been withheld and that the amount claimed is an accurate assessment of the loss suffered.

I/We further declared that the information written in this claim form or held by Etiqa Insurance Pte. Ltd. Whether contained in my/our insurance application or otherwise obtained may be used and disclosed to your authorized staff, associated individuals and/or companies or any independent third parties (within or outside Singapore) who will provide claims administrative, advice and/or information or claim services in relation to my/our claim. I/We understand my/our data that may also be used for audit, business analysis and reinsurance purposes. My/Our signature below will signify this consent.

_____ _____

Date

Signature of Insured
Company's stamp (if applicable)

The questions overleaf must be answered by a registered Medical Practitioner.



**Etiqa Insurance Pte. Ltd.** (Co. Reg No.: 201331905K) 23 Church Street, #01-01 Capital Square, Singapore 049481
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## Attending Physician's Medical Report

Note: I) The Insured Person/Claimant must obtain at his/her own expense the Medical Report from Attending Physician/Surgeon
II) This report must be completed by the Attending Physician/Surgeon whose replies should be as full as possible

### The Insured

| | |
|---|---|
| 1. Name of Patient | |
| 2. Admission Period | |

3. Final Diagnosis (Based on ICD, 1975 Revision, WHO) of illness or extent of injury

4. What is the cause of the illness/injury ?

5. Please specify the approximate date of discovery of the illness/injury:

6. How long has the illness/injury been existing prior to consulting you?

7. When did the patient first consult you for this condition?

8. Did the patient has any symptoms prior to consulting you? ☐ Yes ☐ No ☐ Not to my knowledge
If YES, please indicate the nature of symptoms and date the symptoms first started:

Doctor(s) previously consulted by the patient for the above condition:

| | Name | Date | Name of Clinic / Hospital | Address |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |

9. Describe the surgical procedures / treatment rendered. If no surgery was performed, please state the treatment / medication given.

Date of surgical procedures / treatment rendered:

10. Is the patient still under your care for this condition? ☐ Yes ☐ No
If NO, please give the date service was terminated, and furnish name and address of doctor if the patient has been referred to another doctor for follow-up:

11. What is the prognosis of this illness?

12. Is this treatment related to the following:

| | | | | | |
|---|---|---|---|---|---|
| (a) Pregnancy or Childbirth? | ☐ Yes | ☐ No | (f) Refractive error of the eye? | ☐ Yes | ☐ No |
| (b) Abortion or miscarriage? | ☐ Yes | ☐ No | (g) Dental surgery / treatment? | ☐ Yes | ☐ No |
| (c) Infertility or sub-fertility condition? | ☐ Yes | ☐ No | (h) Mental or nervous disorder? | ☐ Yes | ☐ No |
| (d) Sexually transmitted disease? | ☐ Yes | ☐ No | (i) Self inflicted injury? | ☐ Yes | ☐ No |
| (e) Congenital anomaly; a physical defect at birth; a genetic condition? | ☐ Yes | ☐ No | (j) Cosmetic Surgery? | ☐ Yes | ☐ No |

13. (a) Is this condition related to any accident or injury? ☐ Yes ☐ No
(b) Is this a work related illness or accident? ☐ Yes ☐ No
If YES to any of the above (a) or (b), please provide the date of the accident and explain the extent of the injury sustained.

### Declaration

I hereby certify that the above patient had been examined and treated by me for the above * injuries / illness and the statement given above present my opinion of his / her condition.

Signature of Physician/Surgeon

Date

Name / Designation
* to delete as applicable

Name, Address and Stamp of Clinic / Hospital



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