

## Maid Claim Form

Policy Number		Policy Holder's Full Name	
Policy Holder's NRIC/FIN No.		Policy Holder's Mobile No.	
Policy Holder's Email			
Name of Maid		Maid's Age	
Date of Employment		Work Permit Number	

**Important Notice**

1. The Policyholder and/or the claimant must truthfully declared the information and particulars to the best of your / their knowledge and belief.
2. The acceptance of this form is not in itself an admission of liability on the part of the Company.
3. If the claim is found to be fraudulent, or if any fraudulent means or devices are used to obtain any benefit under this policy, the policy will be rendered void.

This form is issued without admission of liability.

Type of Accident	
<input type="checkbox"/> Sickness <input type="checkbox"/> Wages & Levy Reimbursement <input type="checkbox"/> Termination / Re-Hiring Expenses <input type="checkbox"/> Recuperation Expenses <input type="checkbox"/> Letter of Guarantee to Philippine Embassy	<input type="checkbox"/> Injury <input type="checkbox"/> Repatriation Expenses <input type="checkbox"/> Maid's Liability <input type="checkbox"/> Special Grant

Sickness	
Diagnosis	
Date Symptoms First Began	Date First Treated
Is the sickness arising from employment? (Yes / No)	
Has the sickness been treated previously? (Yes / No)	
If yes, please state name and address of Physician.	
Date of Last Treatment	
Is the sickness due to pregnancy, abortion, sterilization or infertility? (Yes / No)	
If yes, specify condition and approximate date of commencement.	
Date of Last Treatment	
Name and Address of Family Doctor	
Name and Address of Hospital / Clinic	

Injury	
Date of Accident	Time of Accident
Is this a job related accident? (Yes / No)	
Name and Address of Hospital / Clinic	

Wages and Levy Reimbursement			
Date of Hospitalisation			
Monthly Earnings		Monthly Levy	

Repatriation Expenses	
Date of Repatriation	
Amount Claimed	

Termination / Re-Hiring Expenses	
Date of Accident / Death	
Amount Claimed	

Maid's Liability	
Date of Accident / Death	
Amount Claimed	

Recuperation Expenses	
Date of Accident	
Amount Claimed	

Documents Required for Claim Assessment	
Type of Accident	Documents Required
Sickness	<input type="checkbox"/> Original bills (to be mailed) <input type="checkbox"/> Attending Physician's Report <input type="checkbox"/> Copy of work permit
Injury	<input type="checkbox"/> Original bills (to be mailed) <input type="checkbox"/> Copy of work permit
Wages of Levy Reimbursement	<input type="checkbox"/> Copy of salary voucher / bank statement <input type="checkbox"/> Copy of levy payment <input type="checkbox"/> Copy of work permit
Repatriation Expenses	<input type="checkbox"/> Doctor's letter to certify maid is physically unfit <input type="checkbox"/> Repatriation expenses bills <input type="checkbox"/> Burial / cremation or conveyance of body expenses <input type="checkbox"/> Copy of work permit
Termination / Re-Hiring Expenses	<input type="checkbox"/> Bills for expenses incurred <input type="checkbox"/> Death certificate (if any) <input type="checkbox"/> Copy of work permit
Maid's Liability	<input type="checkbox"/> Medical bills incurred by injured claimed <input type="checkbox"/> Death certificate (if any)
Recuperation Expenses	<input type="checkbox"/> Medical Certificate <input type="checkbox"/> Copy of hospital bills <input type="checkbox"/> Copy of work permit
Special Grant	<input type="checkbox"/> Death certificate (if any) <input type="checkbox"/> Copy of work permit
Letter of Guarantee to Philippine Embassy	<input type="checkbox"/> Copy of letter from embassy <input type="checkbox"/> Copy of work permit



**Declaration**

- 1) [Declaration] I/We declare that the information given in this form is true and correct to the best of my knowledge and belief.
- 2) [Authorization] I/We hereby consent to and authorize the medical practitioner involved in the claimant's care to discuss and disclose treatment details and discharge arrangements with and to Etiqa Insurance Pte Ltd. I/We agree that a copy of this consent shall have the validity of the original.
- 3) [Customer's Data Privacy Consent] 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 authorised 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 claims 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.

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Date

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Signature of Insured  
Company's stamp (if applicable)