MEDICAL CLAIM FORM

SECTION I – PARTICULARS OF POLICYHOLDER/INSURED AND INSURED PERSON/CLAIMANT

Name of Policyholder/Insured _____ Policy No. _____

Trade/Occupation _____ Address for Correspondence _____

_____

Name of Insured Person/Claimant _____ Address (Home) _____

_____

Relationship to Policyholder/Insured _____ Date of Birth _____ Sex : Male/Female

NRIC No. _____ Occupation _____

Telephone No. Office _____ Home _____ Mobile _____

SECTION II – TO BE COMPLETED BY EMPLOYER

OTHER INSURANCE

Is the Insured Person/Claimant entitled to claim against Workmen's Compensation Benefits, Employers' Medical Benefits Programme or insurance other than from Allied World Assurance Company, Ltd Yes ☐ No ☐ If Yes, please advise

Name of Insurer _____ Date of Employment _____

Policy Details _____

SECTION III – MEDICAL INFORMATION AUTHORITY (MUST BE COMPLETED BY INSURED PERSON/CLAIMANT)

(A) MEDICAL INFORMATION AUTHORITY AND (B) PERSONAL DATA PROTECTION ACT (MUST BE COMPLETED BY INSURED PERSON)

I, _____ NRIC No. _____

hereby authorise any hospital, surgeon, medical practitioner, clinic, insurance office or other person or organisation who has attended to me for any reason, to disclose to Allied World Assurance Company, Ltd any and all information with respect to any illness or injury and to provide copies of all hospital or medical records/certification including earlier medical history. A copy of this authorisation shall be considered as effective and valid as the original. The information given is true and correct to the best of my knowledge and belief.

I/We declare and acknowledge that: (i) all information given in this form is true and correct to the best of my/our knowledge and belief; (ii) I/We have not concealed or suppressed any material fact or made any false statement in relation to the claim; and (iii) I/we acknowledge and consent to Allied World collecting, using, disclosing and processing my/our personal data for the purposes of managing and administering my/our claim including disclosing my/our personal data to third party service providers within or outside Singapore in accordance with the Allied World Singapore Personal Data Protection Policy available at https://www.awac.com/asiapacretail.

_____ _____

Signature of Policyholder/Insured Signature of Injured Person / Date

NOTE: The issuance of this form is not an admission of liability by the Insurer.
The section overleaf must be completed by the Insured Person/Claimant's Attending Physician/Surgeon. The Policyholder/Insured must obtain at his/her own expense the Medical Report from the Insured Person/Claimant's Attending Physician/Surgeon and Allied World Assurance Company, Ltd will reimburse the Policyholder/Insured up to the limit as stated in the Policy. Cheque will be made in favour of the Policyholder/Insured.
To submit your claim, please attach all original medical bills and receipts together with this form. If Medisave/Medishield were used, the appropriate amount would be credited into the respective Medisave/Medishield Account.

Allied World Assurance Company, Ltd (Singapore Branch)
Registered Office: 60 Anson Road #08-01 Mapletree Anson Singapore 079914 UEN No. T09FC0142D
Telephone (65) 6220 1188 Facsimile (65) 6423 0798 Website: www.awac.com

MEDICAL REPORT

NOTE: This Section must be completed by the Insured Person/Claimant's Attending Physician/Surgeon whose replies should be as full as possible.

SECTION IV – TO BE ANSWERED ONLY IF INJURY DUE TO ACCIDENT

1. Date and Time of Accident
2. Circumstances and Place of Accident
3. Is injury due to patient's employment? Yes ☐ No ☐
4. Was the patient under the influence of drugs or intoxicants at the time of accident? Yes ☐ No ☐
5. Give full particulars of operation performed/surgical procedure

SECTION V – TO BE ANSWERED IF DUE TO ILLNESS / SICKNESS

1. Give full particulars of operation performed/surgical procedure
2. Give cause of illness/condition
3. Date of Admission Date of Surgery performed Date of Discharge
4. Is the patient still under your care for this illness/condition? Yes ☐ No ☐ If No, date your service was terminated.
5. When did symptoms first appear?
6. When did patient first consult you for this illness/condition?
7. How long did the patient suffer from this illness/condition before consulting you?
8. In your professional opinion, when do you think patient first suffered from this illness/condition?
9. Was the patient referred to you? If so, please give name and address of referring doctor.
10. What is your diagnosis of this illness
    a) Primary
    b) Secondary
    c) Others
11. What is your prognosis of the illness?
12. Is this illness/condition likely to recur?
13. Was the patient's illness/condition a congenital anomaly?
14. Was patient's illness/condition related to pregnancy, miscarriage, abortion, sterilization, infertility or childbirth? If yes, please specify condition and approximate date of commencement
15. Was the patient's illness/condition due to self-destruction or intentional self-inflicted injury?
16. Was the patient's illness/condition a mental or nervous disorder?
17. Was this surgery for cosmetic reasons or dental treatment or an elective surgery?
18. Has the patient previously been treated for this illness/condition or any other serious disorder? If Yes, please state
    Date Diagnosis & Date of Diagnosis Details of treatment Name of Doctor/Hospital

I hereby certify that the foregoing statement are correct.

Name and qualification of Doctor

Name and Address of Hospital/Clinic

Tel No.

Fax No.

Signature of Doctor / Date