Liberty Insurance

www.libertyinsurance.com.sg

# Claim Form

## Group Hospital & Surgical Student Medical Insurance

Please complete all sections to facilitate the processing of your application. This form is issued without admission of liability and it must be completed and returned to us immediately, whether or not a claim is made. Any documentary proof or report required by Liberty shall be furnished at the expense of Policyholder or Claimant.

Please submit the following documents within 30 days from the date of discharge from hospital.

**For hospitalization in Government/Restructured Hospital**

1. Duly completed and signed claim form (Page 2) and a copy of student pass
2. All original final hospital bills, doctor's/specialist's bills and receipts
3. Inpatient Discharge Summary
4. Inpatient Admission Report (if available)
5. Day Surgery Admission Report (if available)

**For hospitalization in Private Hospital/Hospital outside Singapore during school-related activities**

1. Duly completed and signed claim form (Page 2) and a copy of student pass
2. All original final hospital bills, doctor's/specialist's bills and receipts
3. Medical Report from attending physician/specialist (page 3)
4. Inpatient Admission Report (if available)
5. Day Surgery Admission Report (if available)

Please submit the completed documents to:
SINGAPORE POST CENTRE P.O. BOX 15 Singapore 914001 (Student Medical Insurance Claim)

For Claim information and enquiries, please contact:

Ms Christina Chng @ 9760 2569
Email: christina@enrichadvisory.com

Ms Genna Ang @ 9671 5922
Email: genna@enrichadvisory.com

## Information of Policyholder

| **Name of Private Education Institution (PEI):** | **Policy No.:** |
|---|---|
| SINGAPORE COLLEGE OF TRADITIONAL CHINESE MEDICINE LIMITED | SD20M02713 (2020) |

## Information of Student Details

| | | |
|---|---|---|
| **Name of Student:** | | **Gender:** ☐ Male ☐ Female |
| **NRIC/FIN No.:** | **Date of Birth:** | **Contact No.:** |
| **Mailing Address:** | | Postal Code ( ) |
| **Email Address:** | | **Course Start Date:** |
| **State nature of illness & date upon which symptoms first occurred:** | | **Plan No.:** N.A |
| **Did you seek medical treatment prior to being diagnosed with the illness for which you are claiming now?** If Yes, please state the name of insurer and policy no. | | ☐ Yes ☐ No |

## Information of Student Details

| | | |
|---|---|---|
| **Are you claiming from any other insurer in respect of this illness/injury?** | ☐ Yes | ☐ No |
| **If Yes, please state the name of insurer and policy no.** | | |
| _____ | | |

## Type of Accident

| | | |
|---|---|---|
| **How did the accident happen?** | **Road-related** | ☐ Yes ☐ No |
| _____ | **Work-related** | ☐ Yes ☐ No |
| | **Others** | ☐ Yes ☐ No |
| **Describe the nature of injuries sustained:** | | |
| _____ | | |
| **Date & Time of Accident:** | **Place of Accident:** | |
| _____ | _____ | |

## Claims Payment Details

| | | |
|---|---|---|
| **Claim amount to be made payable to:** | ☐ Private education institution/school | ☐ Student (uncrossed check) |

All check payments and claim documents will be delivered to the private institution/school.

**PERSONAL DATA PROTECTION**

I, the Student, give consent to Liberty Insurance Pte Ltd and its employees, related companies, agents and service providers to collect, use and disclose my personal data for one or more of the purposes described in Liberty Insurance Pte Ltd's Data Protection Policy including but not limited to administering & processing my claim, communicating with me including via the telephone numbers I furnished via voice calls, text messages or faxes; investigations, underwriting, information-sharing, reinsurance, debt recovery, accounting, audit, regulatory, research & surveys. I have read and agreed to the terms of the full Policy at www.libertyinsurance.com.sg/data-protection-policy/.

**DECLARATION**

I, the Student, 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 damage or exaggerated the claim or sought unjustly to benefit by any fraud or wilful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty Insurance reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me. I authorize the release of any medical information necessary to process this claim.

_____
Student's signature

Date:

_____
Name of PEI Administrator & signature

PEI's Stamp:

Date:

## Medical Information (to be completed by the attending physician*)

| | |
|---|---|
| **Name of Patient:** | **NRIC/FIN No.:** |
| **Date when the patient first consulted you:** | **Prior to the first consultation with you, when did the patient first suffer the symptoms of the condition:** |
| **Presenting complaints:** | **Duration of illness/injuries at time of consultation:** |

**Was the Patient referred by another physician?** ☐ Yes ☐ No

If Yes, please provide details:

Name of Physician: Address: Contact No.:

**State your diagnosis of the illness/injuries:**

## Investigations Done

**Blood Test** ☐ Yes ☐ No Others, please specify:

**X-Ray** ☐ Yes ☐ No

If Yes, please furnish copies of the reports/investigation results

**Type of surgical operation(s) done:**

| | |
|---|---|
| **Date of Admission:** | **Date of Discharge:** |

**Is there any connection between the present condition and any other pre-existing illness or previous accident?** ☐ Yes ☐ No

If Yes, please provide details:

**Is the condition of the patient:**

| | | | | | |
|---|---|---|---|---|---|
| Congenital in nature | ☐ Yes | ☐ No | Sexually transmitted disease | ☐ Yes | ☐ No |
| Genetic or chromosomal disorder | ☐ Yes | ☐ No | Related to cosmetic treatment | ☐ Yes | ☐ No |
| Mental/psychiatric disorder | ☐ Yes | ☐ No | Infertility related | ☐ Yes | ☐ No |
| Drug addiction/alcoholism | ☐ Yes | ☐ No | Treatment of teeth/gum tissue/oral | ☐ Yes | ☐ No |
| Self-inflicted injury | ☐ Yes | ☐ No | cavity | | |
| | | | Pregnancy related | ☐ Yes | ☐ No |

If any of the above is Yes, please provide details:

**Will illness/injury require further follow-up treatment** ☐ Yes ☐ No

If Yes, please provide details:

## Investigations Done

Any other relevant information:

_____

I hereby certify that I have personally examined and treated the patient for the above illness/injuries and that the facts are given above present my opinion of the patient's condition.

_____
Date

_____
Signature of Physician
Name of Physician:

Contact No.:

Company Stamp: