

# Medical Claim Form

QBE Insurance (Singapore) Pte Ltd



The Insured shall within 31 days of an event giving rise to a claim under the policy, give written notice to QBE stating full particulars of the claim.

## Outpatient

- 1) Completed Claim Form (Page 1)
  - 2) Original tax invoice
  - 3) Copy of referral letter for first visit to specialist
  - 4) Copy of I/C/work permit/passport
  - 5) Copy of valid student pass for children above 19 years old
  - 6) Read and complete Section E (Page 3)
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## Inpatient (Hospitalisation/Surgery)

- 1) Completed Claim Form (Page 1)
  - 2) Completed Page 2 of claim form (applicable to hospitalisation/surgery at private/overseas hospital/clinic)
  - 3) Original final detailed hospital tax invoice
  - 4) Copy of inpatient discharge summary/pre-admission authorisation form (applicable to hospitalisation/surgery at government/restructured hospitals)
  - 5) Copy of all investigation results/report
  - 6) Copy of valid student pass for children above 19 years old
  - 7) Copy of I/C/work permit/passport
  - 8) Copy of police report for claims involving road traffic accident
  - 9) For special grant/repatriation benefit
    - a. Copy of death certificate
    - b. Copy of permit to export
    - c. Original receipt for expenses incurred for repatriation
  - 10) Read and complete Section E (Page 3)
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**Section A: To Be Completed By Policyholder**

Policyholder	Policy No.
Name of Patient	NRIC/FIN No.
Name of Employee (if different)	NRIC/FIN No.
Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
Room & Board Entitlement Per Day	Date of Admission

**Section B: To Be Completed By Policyholder**

Details of Employee					If Patient is a Dependant			
Date of Birth (DD/MM/YYYY)	Gender	Date of Employment	Occupation	Plan Type (Room & Board)	Date of Birth (DD/MM/YYYY)	Gender	Effective Date of Insurance	Occupation
Signature of Policyholder			Company's Name and Stamp			Date		

**Section C: To Be Completed By Employee/Patient**

Nature of Illness/Accident	Nature of Treatment (if any)	Date Illness First Discovery/Occurrence
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(This part must be signed by the patient or patient's parent/ legal guardian if patient is a minor)

I, the undersigned, hereby declare that the particulars stated on this form are true in every respect and that I have supplied full information on all particulars relevant to this claim. I authorise any physician or other person who has attended to me, or my dependant to release any information acquired in the course of examination or treatment to QBE Insurance (Singapore) Pte Ltd. I also authorise the hospital to release and provide any billing documents, invoices or other information relating to me or my dependant directly to QBE Insurance (Singapore) Pte Ltd in any form or mode of transmission when requested by them. A copy of this authorisation shall be considered as effective and valid as the original.

I, the undersigned, have read and agree to the clauses described in Section E at page 3 of this claim form relating to the Personal Data Protection Act.

Signature of Employee	Signature of Patient	Date
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**Section D: To be completed by your attending physician/surgeon if you were admitted to a private hospital/clinic/overseas hospital**

A. Name of Patient \_\_\_\_\_

B. (i) Final Diagnosis and ICD Code (Based on ICD, 1975, WHO) \_\_\_\_\_

(ii) What is the cause of illness/injury? \_\_\_\_\_

(iii) Patient's description of the symptom(s) and duration experienced, or how the injury was sustained \_\_\_\_\_

(iv) Has the patient ever suffered from an episode of similar injury or symptom(s) including similar symptom(s) of lesser severity, chronic or acute or which wax and wane, or relapse and remit intermittently  Yes  No  
 Has this diagnosis been made in the past?  Yes  No

(v) Date patient first developed symptom(s) or when injury was first sustained \_\_\_\_\_

(vi) Date patient first sought medical treatment for the described symptom(s), or injury \_\_\_\_\_

(vii) Name of the doctor, clinic or hospital consulted when symptom(s) first developed \_\_\_\_\_

(viii) Name of other doctors, clinics or hospitals visited previously with reference to the symptoms or injury described in para iii, iv & vi \_\_\_\_\_

(vi) Date patient first sought medical treatment for the described symptom(s), or injury \_\_\_\_\_

Name of doctor, clinics/hospitals	Exact date of visit, or year where the exact date is not available

C. (i) Name of the doctor who referred the patient to you (Please attach a copy of the referral memo with this report) \_\_\_\_\_

(ii) Was the patient already on long term medication or regular follow-up with a doctor for the illness/injury stated in para B.(i)? If "Yes", what long term medication is the patient using and what history of regular follow-up did the patient offer? \_\_\_\_\_

D. (i) The exact name of the surgical procedure(s) or treatment rendered. (Please attach such other reports as, histology/gastro-colono, cardiac report, etc., when returning this report) \_\_\_\_\_

Date of surgery or treatment rendered	Operation table and code

(ii) If no surgery was performed, please state treatment/medication given \_\_\_\_\_

E. What is the prognosis of this condition? \_\_\_\_\_

F. Is this treatment related to

(i) past or recent pregnancy or childbirth?  Yes  No

(ii) abortion or miscarriage?  Yes  No

(iii) infertility/subfertility condition  Yes  No

(iv) correcting infertility/subfertility condition?  Yes  No

G. Is this condition

(i) a congenital anomaly; a physical defect at birth; a genetic condition?  Yes  No  
 If "Yes", when was it first made known to the patient? \_\_\_\_\_ (Please indicate date)

(ii) a mental or nervous disorder?  Yes  No

(iii) a refractive error of the eye?  Yes  No

(iv) due to intentional self inflicted injury or drug overdose; excessive consumption of alcohol; use of narcotics or similar drugs or agents? (If yes, please circle which one)  Yes  No

(v) due to sexually transmitted disease?  Yes  No

H. Is this a cosmetic surgery?  Yes  No  
 If "No", please explain why the surgery is necessary \_\_\_\_\_

I. Is this a dental surgery/treatment?  Yes  No

J. Is this a job related injury?  Yes  No

Signature of Physician/Surgeon and Official Stamp	Name and Address of Clinic/Hospital
Name/Designation	Date

## Section E: Personal Data Protection Act (PDPA) 2012

### Supplementary Consent Clauses

To process, administer and/or manage your relationship, account and policy with QBE Insurance (Singapore) Pte Ltd (QBE), QBE will necessarily need to collect, use, disclose and/or process your personal data or personal information about you. Such personal data includes (i) information set out in this [form] and any other personal information provided by you or possessed by QBE; and (ii) your claims.

Such personal data will be collected, used, disclosed and/or processed by QBE for the purpose(s) of :

- a) considering whether to provide you with the insurance you applied for;
- b) processing your application for underwriting and insurance;
- c) administering and/or managing your relationship, account and/or policy with QBE;
- d) processing and/or dealing with any claims including the settlement of claims and any necessary investigations relating to the claims, under your policy;
- e) carrying out due diligence or other screening activities (including background checks) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by QBE;
- f) carrying out your instructions or responding to any enquiries by you;
- g) dealing in any matters relating to the services and/or products which you are entitled to under this policy which you are applying for or have applied; (including the mailing of correspondence, statements, invoices, reports or notices to you, which could involve disclosure of certain personal data about you to bring about delivery of the same as well as on the external cover of envelopes/mail packages);
- h) investigating fraud, misconduct, any unlawful action or omission, whether relating to your application, your claims or any other matter relating to your policy, and whether or not there is any suspicion of the aforementioned; and/or
- i) complying with applicable law in administering and managing your relationship with QBE.

(collectively the "Purposes")

We may/will also be collecting from sources other than yourself, personal data about you, for one or more of the above Purposes, and thereafter using, disclosing and/or processing such personal data for one or more of the above Purposes.

Your personal data may/will be disclosed by QBE to its third party service providers or agents (including its lawyers / law firms), which may be sited outside of Singapore, for one or more of the above Purposes, as such third party service providers or agents, if engaged by QBE, would be processing your personal data for QBE for one or more of the above Purposes.

By signing below, you:

- consent to QBE collecting, using, disclosing and/or processing your personal data for the Purposes as described above;
- consent to QBE collecting personal data about you from sources other than yourself and using, disclosing and/or processing the same, for one or more of the Purposes as described above;
- consent to QBE disclosing your personal data to its third party service providers, or agents (including its lawyers / law firms), for the Purposes as described above; and
- consent to QBE transferring your personal data out of Singapore to its third party service providers, or agents where such third party service providers or agents are sited (whether in Singapore or outside of Singapore), for the Purposes as described above.

I have read and agree to the above.

Name	Signature
NRIC No.	
Date	

Please send the completed claim forms and the relevant supporting documents to:

QBE Insurance (Singapore) Pte Ltd  
1 Raffles Quay  
#29-10 South Tower  
Singapore 048583