



Liberty Insurance Pte Ltd
 51 Club Street
 #03-00 Liberty House
 Singapore 069428
 Tel: (65) 6221 8611
 Fax: (65) 6224 1047
<http://www.libertyinsurance.com.sg>

MEDICAL CLAIM FORM

Section A. PATIENT INFORMATION (to be completed by patient)

1. Name (Mr/Miss/Mrs/Mdm): _____
2. Date of birth: _____ NRIC/Passport No: _____ Telephone No: _____
3. Address: _____
4. Occupation: _____ Policy No: _____ Plan No: _____
5. Name of Policyholder (For Group Plan Only): _____ Date employed: _____
6. Is policyholder GST- registered? Yes / No If yes, GST registration no. _____
7. If yes, is policyholder allowed to claim the GST on the Insurance Premium paid? Yes / No
8. State nature of illness & Date upon which symptoms first occurred: _____

9. Type of Accident: Road Related: YES/NO Work Related: YES/NO Sports Related: YES/NO Others: ____
 Date of Accident: _____ Time: _____ Place: _____
 How did the accident happen? _____
 In your own words, describe the nature of injuries sustained: _____
10. State policy number & name of insurer of any other health insurance coverage/Workmen's Compensation policy. _____
11. Did you seek medical treatment prior to being diagnosed with the illness for which you are now claiming? YES/NO If YES, state name & address of the physician _____

Date of bill or Treatment	Expenses for which Reimbursement is claimed	Currency & Amount paid	<u>Settlement is to be paid to whom</u>

I authorize the release of any medical information necessary to process this claim. I declare that the information given on this Form is true and that I have not concealed any information relating to this claim.

Signature of Patient: _____ Date: _____

Company's Stamp & Authorized Signature _____ (Mandatory for Group Plan)

Section B. MEDICAL INFORMATION (to be completed by Attending Physician)

Name of Patient: _____

1. Date when the patient first consulted you _____
2. Prior to consulting you, when did patient first suffer the symptoms of the condition _____
3. Presenting complaints: _____
4. Duration of illness/injuries at time of consultation: _____
5. Physical signs of injuries: _____
6. Other evidence consistent with the injuries: _____
7. Was the patient referred by another physician? YES/NO If YES, please state name/address/tel. No.

8. State your diagnosis of the illness/injuries: _____
9. Investigations done: X'Ray: YES/NO Blood Test: YES/NO Others: (Specify) _____
If YES, please furnish copies of the reports for the above.
10. Type of surgical operation(s) done _____
11. Date of Admission: _____ Date of Discharge: _____
12. Is there any connection between the present condition and any other pre-existing illness or previous accident: YES/NO
If YES, give details _____
13. Is the condition of the patient congenital in nature/a genetic or chromosomal disorder/a mental disorder/self-inflicted injury/sexually transmitted disease/related to cosmetic treatment/infertility? YES/NO
If YES, please give details _____
14. Will illness/injury require further follow-up treatment? YES/NO If YES, give details

15. Any other relevant information: _____
16. Your name & address/contact telephone number _____

Signature & Co. Stamp of Attending Physician _____ Date _____