

## MEDICAL CLAIM FORM

*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.*

### POLICYHOLDER INFORMATION

Name:	Is policyholder GST- registered? <input type="checkbox"/> YES <input type="checkbox"/> NO
	If yes, is policyholder allowed to claim the <u>GST</u> on the Insurance <u>Premium</u> paid? <input type="checkbox"/> YES <input type="checkbox"/> NO
Policy No:	Email Address:

### CLAIMANT INFORMATION

Name (Mr/Miss/Mrs/Mdm):	NRIC/Passport No:
	Date of Birth:
	Telephone No:
Address:	Email Address:
Occupation:	Date Employed:
	Plan No:

State nature of illness & date upon which symptoms first occurred:

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:

Are you claiming from any other insurer in respect of this illness/injury?  YES  NO  
 If YES, state name of insurer & policy no:

### TYPE OF ACCIDENT

How did the accident happen?	Road Related <input type="checkbox"/> YES <input type="checkbox"/> NO
	Work Related <input type="checkbox"/> YES <input type="checkbox"/> NO
Describe the nature of injuries sustained:	Others <input type="checkbox"/> YES <input type="checkbox"/> NO
Date & Time of Accident:	Place of Accident:

### BANK ACCOUNT INFORMATION (for GIRO Claims Processing)

Name of Bank:	Bank Code:	Branch Code:
Bank Account No:	Name of Account Holder:	

I 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 willful 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.

\_\_\_\_\_  
*Signature of Claimant*

\_\_\_\_\_  
*Authorised Signature & Company Stamp of Policyholder*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Date*

**MEDICAL INFORMATION (to be completed by attending physician)**

Name of Patient:	NRIC/Passport No:
Date when the patient first consulted you:	Prior to the first consultation with you, when did patient first suffer the symptoms of the condition:
Presenting complaints:	
Duration of illness/injuries at time of consultation:	
Physical signs of injuries and/or other evident consistent with the injuries:	
Was the patient referred by another physician? If YES, state name, address & telephone number:  <input type="checkbox"/> YES <input type="checkbox"/> NO	State your diagnosis of the illness/injuries:

**INVESTIGATIONS DONE**

Blood Test <input type="checkbox"/> YES <input type="checkbox"/> NO	X Ray <input type="checkbox"/> YES <input type="checkbox"/> NO	Others (Please specify)
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?		<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, please give details:		
Is the condition of the patient:		
Congenital in nature <input type="checkbox"/> YES <input type="checkbox"/> NO	Sexually transmitted disease <input type="checkbox"/> YES <input type="checkbox"/> NO	
Genetic or chromosomal disorder <input type="checkbox"/> YES <input type="checkbox"/> NO	Related to cosmetic treatment <input type="checkbox"/> YES <input type="checkbox"/> NO	
Mental disorder <input type="checkbox"/> YES <input type="checkbox"/> NO	Infertility related <input type="checkbox"/> YES <input type="checkbox"/> NO	
Self-inflicted injury <input type="checkbox"/> YES <input type="checkbox"/> NO	Pregnancy related <input type="checkbox"/> YES <input type="checkbox"/> NO	
.....		
If any of the above is YES, please give details:		
Will illness/injury require further follow-up treatment?		<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, please give details:		
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 as given above present my opinion of the patient's condition.

\_\_\_\_\_  
*Signature of Physician*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Name of Physician*

\_\_\_\_\_  
*Telephone Number*

\_\_\_\_\_  
*Company Stamp*