Liberty Insurance

www.libertyinsurance.com.sg

Claims Form

Medical-Foreign Worker

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.

Information of Policyholder

Name of Policyholder:	**Policy No.:**
Is Policyholder GST registered? ☐ Yes ☐ No If Yes, is Policyholder allowed to claim GST on the Insurance Premium paid? ☐ Yes ☐ No	
Email:	**Contact No.:**
Plan No.:	

Information of Claimant

Name of Claimant:		**Occupation:**
NRIC/FIN No.:	**Date of Birth:**	**Work Permit/S Pass No.:**
Nationality:	**Date Employed:**	**Gender:** ☐ Female ☐ Male
Is the condition/disability suffered due to:		☐ Illness ☐ Accident
If the condition/disability suffered is due to illness, please provide the following: i. Diagnosis: ii. Date of symptoms started: iii. Details of all symptoms and nature of medical condition/disability suffered:		
Detailed description of injuries/disability suffered:		
If disability is due to accident, please provide detailed description of accident (Please enclose a copy of the police report if any):		
Are you claiming from any other insurer in respect of this illness/injury? ☐ Yes ☐ No If Yes, please state:		
Name of Insurance Company:		**Policy No.:**

Details of Accident

How did the Accident happen?	Work-Related: ☐ Yes ☐ No
Describe the Nature of Injuries sustained:	

Date of Accident:	Time of Accident:	Place of Accident:

Bank Account Information for Electronic Transfer

Name of Bank:	Bank Code:	Branch Code:

Bank Account No.:	Name of Bank Account Holder:

I agree to hold Liberty Insurance Pte Ltd harmless and that it is fully and finally discharged of its obligations once it has made payment to the bank and bank account number given above.

PERSONAL DATA PROTECTION

I give consent to Liberty Insurance Pte Ltd and third-parties including related entities, employees, agents, other insurers, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to myself or other individuals that I have furnished in the past, present & in the future, for one or more of the purposes described in Liberty's Data Protection Policy, including but not limited to considering whether to provide insurance, carrying out due diligence, pricing, administering and servicing my policies, communicating with me, renewals, reinsurance, collections, claims, accounting, audit, legal, compliance, research, analysis, information-sharing, surveys, data storage & backups. I have read and agreed to the full Policy at www.libertyinsurance.com.sg/data-protection-policy/. If there is any personal data relating not to myself but to other individuals that I have furnished in the past, present & in the future, I warrant that I have obtained prior consent from these data subjects (or if they are lacking in legal capacity, from their legal representatives, guardians or parents as the case may be) for Liberty Insurance Pte Ltd and its Appointees to collect, use and disclose their personal data for the abovementioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform Liberty of any changes to the personal data to my knowledge as soon as practicable.

DECLARATION

1) 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.

_____ _____

Date Signature of Claimant

_____ _____

Date Signature of Policyholder & Company Stamp

Medical Information (to be completed by 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:	
Was the Patient referred by another physician? ☐ Yes ☐ No If Yes, please state:	
Name of Physician:	**Contact No.:**
Mailing Address: Postal Code ( )	
State your diagnosis of the illness/injuries:	
Details of Surgical Operation(s)/Procedure(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 give details:	

Is the Condition of the Patient:

Hereditary or Congenital in nature	☐ Yes	☐ No
Psychological/Mental Condition	☐ Yes	☐ No
Self-inflicted injury	☐ Yes	☐ No
Attempted Suicide	☐ Yes	☐ No
Sexually transmitted disease	☐ Yes	☐ No
Related to cosmetic treatment	☐ Yes	☐ No
Infertility related	☐ Yes	☐ No
Pregnancy related	☐ Yes	☐ No
Drug/Alcohol related	☐ Yes	☐ No

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

Is the Condition of the Patient related to an Accident? If Yes, please provide details of the Accident, whether it is work-related and if police report was made?	☐ Yes	☐ No
Will illness/injury require further follow-up treatment? If Yes, please provide details:	☐ Yes	☐ No

Medical Information (to be completed by attending physician)

Any other relevant information: _____

Please furnish copies of all the reports/investigations results.

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.

_____
Date

_____
Signature of Physician
Name:
Contact No.:
Company Stamp: