Liberty Insurance.

www.libertyinsurance.com.sg

Claims Checklist

Medical

Step 1: Prepare the following documents

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

Basic Requirements	❑ Complete the Claim Form ❑ All **original** final tax invoices and itemized bills/receipts
Hospital Specific Requirements (For admission to government/ Restructured Hospital)	❑ Inpatient Discharge Summary
Hospital Specific Requirements (For admission to Private Hospital/ Specialists Clinics)	❑ Ensure that the medical information section of the claim form is filled OR ❑ include medical report from attending physician
If Available:	❑ Referral letter from General Practitioner to Hospital/Specialist Clinic ❑ Claim settlement advice letter from MediShield Integrated Plan ❑ Inpatient/Day Surgery/Clinical/Medical Report ❑ Other supporting medical documents which are useful for claims assessment

Step 2: Submit documents

Submit the above documents to the following address: 51 Club Street Liberty House Singapore 069428

Step 3: Contact points

Liberty Medical Email	Reach the medical claims team directly at medical_claims@libertyinsurance.com.sg for enquires on your claims, including claims status
ClaimsConnect Medical Hotline	Call medical claims personnel at 1800-LIBERTY (5423 789) for clarifications on claims process

Liberty Insurance

Claims Form

Medical

www.libertyinsurance.com.sg

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.

Section A – Basic Particulars

Information of Policyholder

Name of Policyholder:	**Policy No.:**	
Is Policyholder GST – registered? If Yes, is Policyholder allowed to claim GST on the Insurance Premium paid?	❑ Yes ❑ Yes	❑ No ❑ No
Email:	**Plan Type:** ❑ proMedico ❑ proMedico Plus	 ❑ proMediCare ❑ proMediCash

Information of Claimant

Name of Claimant:		**Policy No.:**
Mailing Address:		Postal Code ( )
NRIC/FIN/Passport No.:	**Date of Birth:**	**Contact No.:**
Occupation:	**Date Employed:**	**Gender:** ❑ Female ❑ Male
Email:		

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.

Section B - Diagnosis

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 conditions/disability suffered: ______________________

Did you seek medical treatment prior to being diagnosed with the illness for which you are now claiming? If Yes, please state:___	❑ Yes	❑ No
Name of Physician: ___		
Mailing Address: ___	Postal Code	( )

Details of Accident

If disability is due to accident, please provide us with the following:

Date of Accident: ___	**Time of Accident:** ___	**Place of Accident:** ___
How did the Accident happen? ___		
Describe the Injuries sustained: ___		
Road-Related ❑ Yes ❑ No	**Work-Related** ❑ Yes ❑ No	**Others:** ___
Are you claiming from another insurer in respect of this illness/injury? If Yes, please state:___	❑ Yes	❑ No
Name of Insurance Company: ___		**Policy No.:** ___

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.
2) The personal data of the individuals (the "**3rd Party Individuals**") which I/we am/are providing to you in this form are accurate and complete. I/we warrant that I/we have obtained consent from the 3rd Party Individuals (or if lacking in legal capacity, his/her legal representatives, guardians or parents as the case may be) for Liberty to collect, use and disclose his/her personal data for the above purposes and on the terms in this document, and as if the said data are about me/us. I/We will inform Liberty of any changes to the data as soon as practicable.
3) I/We have read and agree to the above, including as to how my personal data may/will be collected, used, disclosed and processed by Liberty and others as stated above.

________________________________ Date

________________________________ Signature of Claimant

________________________________ Date

________________________________ Signature of Policyholder & Company Stamp

Section C: 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: ______________________________

International Classification of Diseases (ICD) 10 code (mandatory field): ______________________________

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 provide details:
____

Is the Condition of the Patient:

Hereditary or Congenital in nature	❑ Yes	❑ No
Genetic or chromosomal disorder	❑ 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? ❑ Yes ❑ No
If Yes, please provide details of the Accident. Whether it is work-related and if police report was made?
____

Will illness/injury require further follow-up treatment? ❑ Yes ❑ No
If Yes, please provide details:
____

Medical Information (to be completed by attending physician)

Any other relevant information: ____

Please furnish copies of all the reports/investigations results.

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 Physician
Name:
Contact No.:
Company Stamp: