

### Claims Form – Foreign Worker (Medical)

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?		
If yes, is Policyholder allowed to claim <u>GST</u> on the insurance premium paid?		
Email: _____		Contact No.: _____
Plan No.: _____		

#### Information of Claimant

Name of Claimant: _____		Occupation: _____
NRIC/FIN No.: _____	Date of Birth: _____	Work Permit/Pass No.: _____
Nationality: _____	Date Employed: _____	Gender: _____
Is the condition/disability suffered due to:		
If the condition/disability suffered is due to illness, please provide the following:		
a) Diagnosis:  _____		
b) Date of symptoms started:  _____	c) Details of all symptoms and nature of medical condition/disability suffered:  _____	



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Detailed description of injuries/disability suffered:

If disability is due to accident, please provide a 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?  
If yes, please state:

Name of Insurance Company:

Policy No.:

Have you been hospitalised or submitted claims for any illness/injury for the past three years? If yes, please provide details of the date and description of the illness/injury.

Date

Description of illness/injury

### Details of Accident

How did the accident happen?

Work-related:

Describe the nature of injuries sustained:

Date of Accident/Loss/Injury:

Time of Accident/Loss/Injury:

Place of Accident/Loss/Injury:

### Bank Account Information for Electronic Transfer

Name of Bank:

Bank Code:

Branch Code:



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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.

### DECLARATION

- a) 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.
- b) I authorise the release of any medical information necessary to process this claim.
- c) I/We have read & agreed entirely to all terms in Liberty's Data Protection Policy, available on request & also at [www.libertyinsurance.com.sg/data-protection-policy](http://www.libertyinsurance.com.sg/data-protection-policy), both now & in advance as it may be amended from time to time.

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Policyholder  
(Company stamp, if applicable)



## Claims Form – Foreign Worker (Medical)

### 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? 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? If yes, please provide details:		
Is the Condition of the Patient: Hereditary or Congenital in nature		
Psychological/Mental Condition		
Self-inflicted injury		



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Attempted suicide	
Sexually transmitted disease	
Related to cosmetic treatment	
Infertility related	
Pregnancy related	
Drug/Alcohol related	
If any of the above is Yes, please provide details: <hr/>	
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? <hr/>	
Will illness/injury require further follow-up treatment? If Yes, please provide details: <hr/>	
Any other relevant information: <hr/>	

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:

