

## Claims Form - 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?	<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
Email: _____		

### 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:
_____	_____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Email: _____		
Is the condition/disability suffered due to:		<input type="checkbox"/> Illness <input type="checkbox"/> Accident
<b>If the condition/disability suffered is due to illness, please provide the following:</b>		
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: _____		



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### Information of Claimant

<b>If disability is due to accident, please provide detailed description of accident</b> (Please enclose a copy of the police report if any): _____		
<b>Did you seek medical treatment prior to being diagnosed with the illness for which you are now claiming?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, please state: Name of Physician: _____ Mailing Address: _____ Postal Code ( )		
<b>Are you claiming from any other insurer in respect of this illness/injury?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, please state: Name of Insurance Company: _____ Policy No.: _____		

### Details of Accident

Date of Accident: _____	Time of Accident: _____	Place 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
	Others <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe the Nature of Injuries sustained: _____		

### 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



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read and agreed to the full Policy at [www.libertyinsurance.com.sg/data-protection-policy/](http://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 authorise the release of any medical information necessary to process this claim.

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Date

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Signature of Claimant

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Date

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Signature of Policyholder & Company  
Stamp



## Claims Form - Medical

### Medical Information (to be completed by the attending physician)

Name of Patient: _____		NRIC/FIN/Passport 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: _____			
<b>Was the Patient referred by another physician?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, please provide details:			
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: _____		
<b>Is there any connection between the present condition and any other pre-existing illness or previous accident?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, please provide details: _____			
<b>Is the Condition of the Patient:</b>			
Attempted Suicide	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Drug/Alcohol related	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Genetic or chromosomal disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hereditary or Congenital in nature	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Infertility related	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Pregnancy related	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Psychological/Mental Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Related to cosmetic treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Self-inflicted injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sexually transmitted disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If any of the above is Yes, please provide details: _____			



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### Medical Information (to be completed by the attending physician)

**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:

Any other relevant information:

Please furnish copies of all the reports/investigations results.

I declare that I have in no manner deliberately 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 authorise the release of any medical information necessary to process this claim

\_\_\_\_\_  
Date

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

Name of Physician:

Contact No.:

Company Stamp:

