Liberty Insurance Pte Ltd
One Raffles Quay #25-01 North Tower
Singapore 048583
Tel: 1800-LIBERTY (542 3789)
Reg. No. 199002791D | GST Reg. No. M2-0093571-3
www.libertyinsurance.com.sg

Claim 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?	☐ Yes ☐ No
If Yes, is Policyholder allowed to claim the GST on the Insurance Premium paid?	☐ Yes ☐ 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: ☐ Female ☐ Male
Email: _____		
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:		_____

Claim Form - Medical

Information of Claimant

If disability is due to accident, please provide detailed description of accident
(Please enclose a copy of the police report if any): _____

Did you seek medical treatment prior to being diagnosed with the illness for which you are now claiming? ☐ Yes ☐ No

If Yes, please state:

Name of Physician:

_____

Mailing Address:

_____ Postal Code ( )

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

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

How did the accident happen?

_____

Road-related	☐ Yes	☐ No
Work-related	☑ Yes	☐ No
Others	☐ Yes	☐ No

Describe the Nature of Injuries sustained:

_____

Payment Details

Please select the claim payment mode.

☐ Cheque

☐ Direct transfer into Policyholder's bank account.
Please provide supporting documents such as a bank statement for verification of payee details. We will not be able to proceed with a bank transfer should there be no supporting documents provided.

Full Name (as shown in the bank account):	Nationality:
_____	_____
Name of Bank:	Bank Account Number:
_____	_____

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 authorise the release of any medical information necessary to process this claim.

_____
Date

_____
Signature of Claimant

_____
Date

_____
Signature of Policyholder & Company Stamp

Claim 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: _____	
Was the Patient referred by another physician? ☐ Yes ☐ No If Yes, please provide details:	
Name of Physician & Clinic: _____	Contact No.: _____
Was there any surgery carried out for this condition? ☐ Yes ☐ No If Yes, please provide details:	

Surgical Operation or Procedure	Date of Operation or Procedure	Surgical ICD Code (For doctor to complete)

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:

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

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

_____

Claim Form - Medical

Medical Information (to be completed by the attending physician)

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
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: