MEDICAL INSURANCE CLAIM FORM
(GROUP GLOBAL HEALTH / MYGLOBAL BENEFIT)

SINGAPORE LIFE LTD.
Group Life & Health Claims
4 Shenton Way, #01-01 SGX Centre 2
Singapore 068807
Tel: 6827 8030
Company Registration No.196900499K

The Insured Member is required to furnish the following documents to his/her Insurance Representative or Singapore Life Ltd. when making a claim:

(1) Complete the following Claim Form.
(2) Attach originals of all relevant documents and final detailed hospital / doctor's bills and receipts and Inpatient Discharge Summary (If applicable)
(3) Your doctor must complete and sign Section B of this Claim Form for hospitalization or day surgery.
(4) Use a new Claim Form for each separate illness or injury.

Please tick☑ the appropriate box:
Kindly advise us if you are claiming for benefits under:
☐ Dental ☐ Maternity ☐ Flexible Wellness/Preventive ☐ Health Screen ☐ Outpatient ☐ Inpatient ☐ Others

SECTION A : TO BE COMPLETED BY POLICYHOLDER POLICY NO: _____

1) Name of Policyholder:	NRIC/Passport No:	Occupation:	Marital Status:	Religion:	Date of Birth:	Gender: ☐M ☐F
2) Name of Patient (if other than Policyholder)	NRIC/Passport No:	Occupation:	Marital Status:	Religion:	Date of Birth:	Gender: ☐M ☐F
3) Present Home Address:			4) Contact No: (O): (M):		5) Email Address:	

DETAILS OF ILLNESS / INJURY

6) Is this treatment recommended or referred by physician or surgeon? ☐ YES ☐ NO If Yes, please state:
a) Name of Referring Physician/Surgeon b) Address of Referring Physician/Surgeon

7) Sickness
a) Date First Begin b) Describe Nature of Sickness and Operation

8) Accident
a) Date of Accident b) Time c) Describe How and When Accident Happened

9) Treatment
a) Date First Treated b) Name & Address of the doctor whom the patient first consulted for the sickness or injury?
c) Name & Address of the doctors or specialist who attended to the patient during his/her hospital confinement

10 a) Date of Admission b) Date of Discharge c) Date of Operation, If any

11) Is the patient presently also insured for medical under another insurance company? ☐Yes ☐No
If Yes, please state
(a) Name of Insurance Company: b) Policy No:

12) **SETTLEMENT OPTION**
Please Tick ☑ your referred settlement mode. Kindly note that the payee refers to the Policyholder or Insured Member only.

(a) **FOR PAYMENT DRAWN IN SINGAPORE ONLY**
☐ Direct Credit: Name of Account Holder:_____ Name of Bank: _____
Name of Branch or Branch Code: _____ Account No: _____

(b) **FOR PAYMENT DRAWN OUTSIDE SINGAPORE**
☐ Demand Draft. Name of payee: _____ Currency Type: _____
☐ Telegraphic Fund Transfer. Kindly note that this settlement option is only available if the payment is more than S$200. Please furnish details:
Name of Account Holder:_____ Name of Beneficiary Bank & Branch: _____
Beneficiary Bank Account : _____ Address of Bank & Branch: _____
SWIF Address / Clearing Code (if applicable): _____ Currency Type: _____

NOTE: (i) For payment drawn outside Singapore, if preferred currency type is not specified, claim will be paid in policy currency. (ii) Payment shall not include clinic, physician and any other medical providers. (iii) If CPF Medisave is used, the appropriate amount would be credited into the respective CPF Medisave account.

DECLARATION & AUTHORISATION (This part must be signed by the patient or patient's parent/legal guardian if the patient is below 21 years of age)

I _____ (NRIC No: _____) hereby authorise Singapore Life Ltd. ("Singlife") to request from any hospital, physician, person or organisation, all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records concerning the patient at any time and authorise the prior mentioned organisations to disclose all such information to Singlife. A photocopy of this authorisation shall be considered as effective and valid as the original.
I declare that the statements and answers stated are true and complete to the best of my knowledge and belief.
I/We declare and undertake that I/we have submitted the actual bills and receipts (including electronic/digital copies) issued by the medical institution.
I/We understand that Singlife has the right to:

- Ask for originals/certified true copies of the bills and receipts, or contact the medical institution directly, to confirm that the bills and receipts are original.
- Reject claims, recover amounts paid or impose additional charges, if the claim is false or where there are multiple claims made.

I/We consent to Singapore Life Ltd. ("Singlife") (and Singlife related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s) and/or managing my/our relationship with Singlife.
I/We also consent to Singlife (and Singlife related group of companies) transferring my/our personal data to Singlife (Singlife related group of companies) and their respective third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.
I/We have read and understood Singlife's Data Protection Policy which may be found at www.singlife.com/pdpa. Singlife's Data Protection Policy may be updated from time to time without notice. I/We am/are aware that I/we should visit your website regularly to ensure that I/we am/are well informed of the updates.

Please Tick ☑ the box to declare if you've lost your original bills or only have duplicated bills: ☐ I declare that my submitted documents are originals and not claiming from 3rd parties.

_____	_____	_____
Signature of Policyholder	Signature of Patient	Date (DD /MM / YY)

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SECTION B: TO BE COMPLETED BY ATTENDING PHYSICIAN / SURGEON (For Outpatient claims, please complete item 1 to 14 only
((The Medical Report Fee, if any will be borne by the Claimant)

Patient Information		
Policy No:	Name of Company:	
Name of Patient:	NRIC/Passport No:	Admission Period:

Nature of Illness	**Nature of Treatment / Surgery**
01) Final Diagnosis (Based on ICD 10) of illness or extend of Injury DRG Code ☐☐☐☐ ICD Code ☐☐☐☐ ICD Code ☐☐☐☐ Date of Diagnosis: _____	05) Date of surgical procedure or treatment rendered : _____ Operation Code ☐☐☐☐☐☐ Operation Table ☐☐
02) Given the aetiology of the condition, please state the estimated date of such condition would be in existence.	06) Describe the surgical procedure or treatment rendered. If no surgery was performed, please state treatment / medication given
03) What is the cause of illness / injury?	07) If excision was performed, please indicate the size of the lesion / tumor. (Please attach a copy of the Histology Report)
04) What is the anatomy of this illness?	08) Name of a) Physician _____ b) Surgeon _____ c) Anesthetist _____
09) Is the condition/treatment related to: a) Pregnancy or childbirth b) Abortion or Miscarriage c) Infertility or Sub-fertility Condition d) Congenital Anomaly e) Genetic or Chromosomal Disorder f) Mental or Psychiatric Condition g) Cosmetic Surgery h) Is the surgery for correction of short sightedness? i) Is the surgery for dental purposes?	Yes / If "Yes", please elaborate. / No a) ☐ _____ ☐ b) ☐ _____ ☐ c) ☐ _____ ☐ d) ☐ _____ ☐ e) ☐ _____ ☐ f) ☐ _____ ☐ g) ☐ _____ ☐ h) ☐ _____ ☐ i) ☐ _____ ☐
Medical History	
10) Please provide the name and address of referring doctor if patient was you.	15) If there is no symptoms presented, what has prompted the patient to see you?
11) When did the patient first consult you for this condition?	16) Please specify the approximate date of discovery of the illness or injury
12) Nature and Date of Treatment rendered	17) How long has the illness / injury existed prior to consulting you?
13) What were the symptoms/complaints prior to consulting you?	18) Has the patient ever had the same or similar condition / symptom? ☐ Yes ☐ No ☐ Not to my knowledge
14) Please indicate the nature of Symptoms and date Symptoms first started	19) Doctors previously consulted by the patient for the above condition. Name of Doctors: _____ First Consultation: _____ Name of Clinic: _____ Address: _____
20) Is the patient still under your care for this condition? ☐ Yes ☐ No If Yes, please state the estimated duration that patient needs to follow up with you.	If No, please give termination date of service and furnish name and address of doctor if the patient has been referred to another doctor for follow up

_____ Signature of Physician / Surgeon

_____ Date

_____ Name / Designation

_____ Name and Address of Clinic / Hospital & Stamp