DOMESTIC MAID INSURANCE MEDICAL CLAIM FORM

This form is issued on a without admission of liability basis. Please complete all sections to facilitate the processing of your application. Any documentary proof or report required shall be furnished at the expense of the policyholder or claimant within 30 days from the date of the event.

PART 1 – To be completed by Employer and Patient (Maid)

1 Particulars of Policyholder

Name of Employer	NRIC/FIN/Passport No.
Policy Number and Plan Type	Contact Person
Contact Number	Email Address
Address	

2 Particulars of Patient (Maid)

Name of Patient (Maid)		Date of employment (DD/MM/YYYY)
Nationality	Gender	Date of Birth (DD/MM/YYYY)
	◯ Male ◯ Female	
Monthly Salary (SGD)	Monthly Levy (SGD)	

3 Medical Condition/Injury of Patient (Maid)

Illness (Please provide details of illness including description of symptoms and attach hospital discharge summary for our reference.)

Date which symptoms first appeared	Duration of symptoms

Accident (Please provide details on extent of injury, circumstances of the accident and accident report.)

Date of accident	Time of accident

Name and Address of attending Doctor

Did you have any surgical operation due to this Illness/Accident?

◯ Yes ◯ No If **Yes**, please provide the date (DD/MM/YYYY) .....

Name and Address of referral Doctor/any other doctor consulted

Name and Address of regular Doctor

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4 Others

Are you entitled to or claiming reimbursement from any other Insurance Company?

◯ Yes ◯ No If yes, please provide the following information:

Name of Insurance Company	Policy Number	Amount Claimed successfully (SGD)

5 Bank Details

Please select preferred payment mode: ◯ Giro ◯ PayNow

Name of Bank	Bank Account Number	Bank Code

Name of Bank Account Holder (as per Bank's record)	UEN / NRIC (Applicable for **PayNow** only)

Email for notification of successful transfer (Please provide only 1 email address)

I agree to indemnify and hold China Taiping Insurance (Singapore) Pte. Ltd. ("CTPIS") harmless against any and all losses (whether direct, indirect, special or consequential) suffered by me or any third party arising from or in connection with CTPIS accepting and acting on my instruction set out above except where such loss is attributable solely to the gross negligence or wilful default of CTPIS. I authorise CTPIS to effect payment in accordance with the instructions set out above.

6 Checklist

I have submitted:

◯ Original Finalised Medical Bills
◯ Inpatient Discharge Summary
◯ Doctor's Report (upon request)
◯ A copy of Employment Contract
◯ Copy of Death Certificate (if applicable)

This checklist is non-exhaustive and China Taiping Insurance (Pte) Ltd reserves its rights to request for additional document(s), proof or other information (including the sighting of the original version of any document(s) that you have submitted) at any time for the purpose of processing this claim.

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7 Personal Data Collection Statement

1. Consent to Privacy Policy

I / We further confirm that I / we have read and understood and hereby consent to the collection, use, disclosure and processing of my / our personal data in accordance with and agree to be bound by CTPIS Privacy Policy which is made available on CTPIS website at www.sg.cntaiping.com/en/privacypolicy, as may be amended from time to time.

I / We agree on my / our behalf and on behalf of every insured person that in addition to the release of information to any medical source, or other entity mentioned in this Application Form, CTPIS is authorised to collect, retain, use and / or disclose as it reasonably deems fit, any information in respect of me / us / any insured person, that is received by CTPIS to its Representatives and relevant third parties, companies within China Taiping Insurance Group, reinsurers, medical organisations, my / our Representatives, financial institutions, credit agencies, investigators, service providers (who may have to disclose my / our data to their service providers such as medical providers, reinsurers, medical evacuation agencies), judicial, regulatory, government, statutory authorities, dispute resolution parties and industry entities) whether within or outside Singapore. As far as reasonably possible, CTPIS will release such information to such parties on the understanding that the information will be kept strictly confidential and be used, disclosed and retained in accordance with relevant law.

2. Say YES to be a China Taiping SG savvy customer! – MARKETING CONSENT

I / We would like to receive first-hand information about CTPIS's products, latest promotions, financial tips and news, and I / we consent to receive such marketing updates from CTPIS and its service providers via:

◯ Email ◯ Mail ◯ SMS and other phone-based messages ◯ Voice call

I / We hereby represent and warrant that I / we am / are the user(s) and / or subscriber(s) of the telephone number provided by me / us in this form or other forms submitted to CTPIS and I / we consent for CTPIS and its service providers to contact me / us. For the avoidance of doubt, where my / our telephone number is a Singapore telephone number, I / we confirm that the foregoing consent applies even though my / our telephone number(s) is / are already registered or may be registered on the National Do Not Call Registry.

I / We confirm that:

(i) I / We have read and understood the provisions in this form;

(ii) the consent that I / we have provided in this form is in addition to, and does not supersede, vary or nullify the consent which I / we have provided previously unless my / our consent is withdrawn through the withdrawal form at: https://bit.ly/marketingconsent.

(iii) I / We understand that I / we may withdraw my / our consent through the withdrawal form at any time.

8 Declaration / Authorisation

1. I declare that the above statements and answers are true and complete to the best of my knowledge and belief. I understand that any false or fraudulent statements or any attempt to withhold material facts whatsoever in respect of this claim, I shall forfeit all rights to claim under the policy.
2. I confirm that I have made full payment of all the bill(s) / invoice(s) that I have submitted to China Taiping Insurance (Singapore) Pte. Ltd. for reimbursement and I have not made any claim and will not make any claim from any other source for the same bill(s) / invoice(s). If I have made a claim from any other source, I agree that I will provide a copy of the settlement agreement between me and such other source. I am aware that China Taiping Insurance (Singapore) Pte. Ltd. will not reimburse me if I have received a full reimbursement from any other source. In the event that China Taiping Insurance (Singapore) Pte. Ltd. has made a reimbursement to me and I have claimed from other source and has been reimbursed more than what I have incurred in total, I agree that China Taiping Insurance (Singapore) Pte. Ltd. has the right to recover the excess payment from me.
3. I / We understand that my / our claim may be rejected, or my / our policy may be treated as void if I / we have made any false or fraudulent statement or deliberately left out any relevant information relating to the incident(s) / event(s) stated on this form or in any document(s) provided to China Taiping Insurance (Singapore) Pte. Ltd.. In all cases, China Taiping Insurance (Singapore) Pte. Ltd. reserves all rights to report me / us to the relevant authorities and recover from me / us all claims that have been paid under my / our policy including any costs incurred by China Taiping Insurance (Singapore) Pte. Ltd. in relation to my / our policy and my / our claim (whether paid or unpaid) under my / our policy.
4. I declare that any photocopy or electronic copy of the documents submitted to China Taiping Insurance (Singapore) Pte. Ltd. are copy of the original documents and I am aware that China Taiping Insurance (Singapore) Pte. Ltd. may reject my claim at any time should it become aware that the document(s) that submitted is not a copy of the original document(s).
5. I hereby authorise any hospital, physician, person or organisation to disclose when requested to do so by China Taiping Insurance (Singapore) Pte. Ltd., all information with respect to any illness, injury, medical history, consultations, prescription or treatments and copies of all hospital or medical records.
6. I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

Signature of Insured (Maid)	Signature of Policyholder (Employer)
Date (DD/MM/YYYY):	Date (DD/MM/YYYY): .....

I hereby declare that the foregoing particulars are true and correct.

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PART II (to be completed by attending Doctor/Surgeon)

9 Attending Doctor's Statement

Name of Patient	FIN/Passport No.	Date of Birth (DD/MM/YYYY)

Name of Hospital (admission)	Date of Admission	Date of Discharge

Dates of 1st consultation and subsequent consultations	Symptoms presented by Patient

Did the patient have any symptoms prior to consulting you?

If yes, please specify the date which the symptoms first started prior to the date of 1st consultation with you.

◯ Yes Date: ..... ◯ No ◯ Not to my knowledge

How long has the illness/injury been existing prior to the date of 1st consultation with you?

Has patient ever had the same or similar condition?	What is the cause of illness/injury?
◯ Yes ◯ No ◯ Not to my knowledge	

Date of diagnosis	Diagnosis of illness or extent of injury

Treatment(s) provided	Surgery performed	Surgery Date (dd/mm/yyyy)

Please provide Name and Address of the Doctor(s) who had treated the Patient previously or referred Patient to you.

Was the condition of the Patient due to the following	Please tick	(If 'Yes", please provide details)
1. Congenital anomaly or genetic defects present at birth	◯ Yes ◯ No	.....
2. Study and treatment of sleeping disorder	◯ Yes ◯ No	.....
3. Dental treatment	◯ Yes ◯ No	.....
4. Sexually transmitted disease	◯ Yes ◯ No	.....
5. AIDS or HIV infection	◯ Yes ◯ No	.....
6. Functional disorder of the mind or nervous mental disorder.	◯ Yes ◯ No	.....
7. Alcoholism	◯ Yes ◯ No	.....
8. Drug addiction	◯ Yes ◯ No	.....
9. Cosmetic or plastic surgery	◯ Yes ◯ No	.....
10. Pregnancy, child birth, infertility or sub-fertility, miscarriage, abortion	◯ Yes ◯ No	.....
11. Self inflicted injuries	◯ Yes ◯ No	.....

Signature & Stamp of Doctor	Name and Address of Practicing Clinic / Hospital
Name of Doctor ..... Date:	

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