HOSPITAL & SURGICAL CLAIM FORM

This form is issued on a without admission of liability. 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.

1 Information of Policyholder and Claimant

Policy Number	Plan Type
Name of Policyholder	**Policyholder's GST Number** (if not GST registered, please put 'nil')
Name of Employee	**Name of Claimant** (if different from employee)
NRIC/Birth Cert./FIN/Passport No.	**Nationality**

Gender	Date of Birth (DD/MM/YYYY)	Date of Employment
◯ Male ◯ Female		

Mailing Address	Contact No.

2 Information of the Medical Condition/Disability

Is the medical condition/disability suffered due to	Date symptoms/disability first began	Date first treated
◯ Illness ◯ Accident		

Diagnosis	Name of Hospital
Date admitted	**Date discharged**

Name & Address of attending physician/surgeon (Name of clinic, if applicable)

Date surgery performed (if any)	If injury was a result of an accident, please provide details		
	Date:	Time:	Place:

Describe how and when accident happened

Was the accident reported to the police? If yes, please provide a copy of the police report. (Report Number if obtainable) ◯ Yes ◯ No

.....

Who do you consider responsible for the accident? ◯ Self ◯ The other party

If other party, please specify name .....

Are you eligible to claim for this treatment against any other insurance policies? ◯ Yes ◯ No

If **Yes**, please give details.

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3 Other Information

Are you covered for the whole or any part of the medical expenses resulting from the above-mentioned illness or accident by :

Workmen's Compensation Insurance ◯ Yes ◯ No

Any other medical benefits schemes / personal accident, life or other forms of insurance ◯ Yes ◯ No

If the answer to any of the above question is **Yes**, please state full particulars:

Name of Insurance Company	
Address of Insurance Company	
Policy Number	**Expiry Date of Policy**
Other Information	

4 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.

5 Checklist

I have submitted:

◯ Original Finalised Medical Bills
◯ Inpatient Discharge Summary
◯ Doctor's Report / Doctor's Memo (upon request)
◯ Copy of CPF letter with Hospital Registration Number (applicable only if the medical bill is paid via Medisave)
◯ 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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6 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.

7 Declaration and Authorisation to Release Information

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 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 Claimant (parent/legal guardian for minor)	Signature of Witness
Name of Claimant:	Name of witness: .....
Date (DD/MM/YYYY):	NRIC/FIN/Passport No: .....

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8 Medical Report by Attending Physician/Surgeon

a. Name of patient .....

b. Diagnosis .....

c. What were the complaints or physical findings?

.....

d. Was the condition related to employment? If **Yes**, please give details. ◯ Yes ◯ No

.....

e. Was the condition due to pregnancy, infertility or childbirth? If **Yes**, please state date of commencement of pregnancy, or date of first treatment for infertility: ◯ Yes ◯ No

.....

f. Was the condition a congenital anomaly; a physical defect at birth; a genetic condition? If **Yes**, please specify. ◯ Yes ◯ No

.....

g. Was the condition a nervous or mental disorder? If **Yes**, please specify. ◯ Yes ◯ No

.....

h. When did the patient first consult you for this condition?

.....

i. Did patient have any symptoms related to this condition prior to consulting you? ◯ Yes ◯ No

j. How long had the patient been troubled by symptoms prior to consulting you?

.....

k. Has patient ever had the same or similar condition or symptoms relating thereto? If **Yes**, please state the date that the symptoms first appear and describe. ◯ Yes ◯ No

.....

l. How long has the above sickness or injury existed?

.....

m. Doctors previously consulted by patient for the above condition?

Name .....

Name of Clinic .....

Address .....

Approximate Date ..... Tel No. .....

n. Name and nature of surgical or obstetrical procedure (if any).

.....

o. Is surgery for cosmetic reason? ◯ Yes ◯ No

p. Date performed .....

q. Is patient still under your care for this condition? If **No**, please provide last date of treatment ◯ Yes ◯ No

.....

r. What is the prognosis of this illness? .....

Signature of Physician / Surgeon

Name & Designation: .....

Date: .....

Name & Address of Clinic/Hospital

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