CLAIM FORM - MEDICAL INSURANCE (INPATIENT VISIT)

PLEASE NOTE

1. Notify or submit your claims to EQI as soon as possible as late claims notification may be a breach of policy condition. (please refer to policy wordings)
2. The acceptance of the form is NOT an admission of liability on the part of the Company.
3. All original final bills, certificates, supporting documents must be provided to substantiate your claim.
4. Complete the claim form and indicate "NA" if not applicable.

Name of Intermediary:	Policy No.:

PARTICULARS OF POLICYHOLDER

Name of Policyholder:	
Address: Postal Code ( ) Contact Person:	
Email:	Contact No.: (Office) (Mobile)

PARTICULARS OF CLAIMANT

Name of Claimant:			
NRIC / FIN No.:	Contact No.:	Gender: ☐ Male ☐ Female	
Date of Birth:	Date of Employment:	Plan No:	Occupation:

DETAILS OF ILLNESS / INJURY

Please state exactly what happened:

State nature of illness / injury:

Date of accident / Date symptoms first commenced: _____

Date condition was first treated: _____

Is this a work-related injury: ☐ Yes ☐ No

Name and address of attending physician:

Has the insured person ever seen a doctor or been treated for any similar condition in the past? ☐ Yes ☐ No

If yes, please state date of previous treatment and name and address of attending doctor for previous treatment:

For road traffic accident claim, please confirm whether the accident involving third party? ☐ Yes ☐ No

If yes, please state:

(i) Vehicle No. of third party: _____

(ii) Motor Insurer of third party: _____

Have you claimed or do you intend to claim from any other insurer for this illness / injury? ☐ Yes ☐ No

If yes, please state:

(i) Name of Insurer(s): _____

(ii) Details of law firm engaged (if any): _____

Do you have any other medical insurance with other insurer? ☐ Yes ☐ No

If yes, please state:

Name of the insurer(s): _____ Policy number(s): _____ Commencement date(s): _____

PAYMENT DETAILS (PLEASE CHOOSE THE PAYMENT MODE)

☐ Cheque	Cheque Payee name (as shown in the bank account): _____ (Note: An administrative fee based on the issuing bank's prevailing charges will be imposed for every lost / re-issued cheque)
☐ PayNow Linked Account	PayNow registered name: _____ PayNow registered NRIC / FIN or mobile number: _____ PayNow registered UEN (for corporate account): _____
☐ Bank Transfer	Bank name: _____ Bank account holder's name: _____ Bank account number: _____

NOTE: EQ INSURANCE COMPANY LIMITED shall not be liable for any losses incurred by you as a result of providing inaccurate PayNow registered details or bank account details. In the event if the PayNow transaction or bank transfer is unsuccessful, **EQ INSURANCE COMPANY LIMITED** will process payment by issuing cheque.

(Letter of Authorisation is required if payee for Cheque or PayNow Linked Account or Bank Transfer is not the insured)

PERSONAL DATA COLLECTION STATEMENT

To evaluate, process and administer this application or transaction, it is necessarily for us to collect, use, disclose and / or process your personal data or personal information about you. Such personal data includes information collected in this form, or in any document provided, or to be provided to us by you or processed by us, or from other sources.

A. Purpose of Collection

The personal data belonging to you and your insured/s may be collected, used and disclosed for the purposes of:

1. carrying out identity checks;
2. deciding whether to insure or continue to insure you and your insured persons;
3. providing advice for product recommendation based on your profile;
4. processing any claims under your policy, including the settlement of claims and any necessary investigations relating to the claims;
5. communicating on any matters relating to the services and / or products which you are entitled to under this policy;
6. respond to your inquiries or instructions and providing ongoing services, under your policy;
7. make or obtain payments and recovering any debt owed to us;
8. detecting and preventing fraud, unlawful or improper activities;

9. conducting market research and statistical analysis;
10. coaching employees for customer service quality assurance;
11. reinsuring risks and for reinsurance administration; and
12. complying with all applicable laws, including reporting to regulatory and industry entities.

B. Disclosure of Data

The personal data belonging to you and your insured/s may be disclosed for the purposes set out in Section A above to the parties below:

1. Third party service vendors, suppliers, agents, reinsurers, or intermediaries;
2. Medical Professionals and Institutions;
3. Local or overseas service third party vendors that provide us with services such as printing, mail distribution, data storage, data entry, marketing and research, disaster recovery or emergency assistance services;
4. Debt collection agencies;
5. Dispute resolution parties;
6. Parties that assist us to investigate, administer and adjudicate claims;
7. Financial institutions;
8. Credit reference agencies;
9. Industry associations; and
10. To any regulatory, government and statutory body to comply with applicable, laws or regulation or upon their valid request.

C. Personal Data Access and Amendments

You can request access to your personal data collected by us, and to make any corrections to your personal data so as to keep it updated. We may charge you a reasonable fee for providing you with the service.

D. Withdrawal Option of the collection and use of your personal data

You may make your request to withdraw your consent, access or correct your personal data by writing to: The Data Protection Officer, EQ Insurance, 5 Maxwell Road, #17-00 Tower Block, MND Complex, Singapore 069110. Alternatively, you can email to dpo@eqinsurance.com.sg.

Neither EQ Insurance nor any of its employees shall be liable for any loss or damage suffered by you or any user as a result of any disclosure of any personal data which you have consented to us and / or any of its employees disclosing.

Altering on this "Personal data collection statement" is strictly prohibited. Any attempt to do so will be of no effect.

DECLARATION AND AUTHORISATION BY INSURED (MUST BE COMPLETED)

I hereby declare that the information stated on this form is true and correct to the best of my knowledge and belief.

I understand that any false or fraudulent statements or any attempt to withold material facts whatsoever in respect of this claim, I shall forfeit all rights to claim under the policy.

By assessing or using this form, in instances where I am not the policyholder and/or insured, I warrant and represent that I have been properly authorized by the policyholder and the applicable insureds (collectively, hereafter the 'Insured') to submit information pertaining to such Insured's claims. I note that I am fully responsible for ensuring the validity of this submission and agree to indemnify EQ INSURANCE COMPANY LIMITED against any loss or claims thereof.

I hereby authorise any hospital, doctor, person(s) or organisation(s) who has / have attended to me / insured for any reason, to disclose to EQ INSURANCE COMPANY LIMITED or its authorised representatives, any and all information with respect to any illness or injury and to provide copies of all hospital or medical records / certifications, consultation, prescription or treatment, including earlier medical history. A photocopy of this authorisation shall be considered as effective and valid as the original.

Claimant's Signature

Name of Claimant: _____

Date: _____

Policyholder's Signature
(Affix company stamp, if applicable)

Name of Authorized Representative: _____

Date: _____

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reg no. 1978-00490-N

A Member of Citystate

ATTENDING PHYSICIAN STATEMENT (TO BE COMPLETED BY ATTENDING DOCTOR / SURGEON)

Medical Certification of treatment to be fully completed by attending surgeon / physician. If treatment is sought in Private Hospital or Hospital outside Singapore, please arrange with your attending doctor to complete this form. You must bear the fee charged (if any) for completion of this form.
We reserve our rights to request for claimant to submit medical reports from other Hospital(s), if necessary.

Patients full name:

NRIC / PP / BC No.: | Date of Birth:

Name of Hospital admitted:

Date admitted: | Date discharged:

Have you seen this patient prior to the above said admission? ☐ Yes ☐ No

If yes, please state the date of the first consultation.

Please indicate the diagnosis of all the conditions treated and give a description of the symptoms of illness or injury:

What was the cause(s) of the injury / illness?

Has the patient ever had the same or any similar condition? ☐ Yes ☐ No

If yes, please state when and describe.

Date of first consultation: | Please give date of previous treatment:

Please give the names and address of the doctor who treated the patient previously:

Is the surgery / treatment for cosmetic reasons? ☐ Yes ☐ No

Is this an elective treatment / surgery? ☐ Yes ☐ No

Was the treatment provided to the patient related to the conditions stated below ☐ Yes ☐ No (If yes, please tick the relevant box)

- ☐ Congenital anomaly
- ☐ Self inflicted injuries or alcoholic or drug addiction
- ☐ Mental / Psychiatric disorder
- ☐ Pregnancy, infertility or childbirth
- ☐ Condition arising directly / indirectly from AIDs, any AIDs related disease or any sexually transmitted disease

Type of operation / surgical procedures performed

a. Date performed: _____

b. Type of operation / surgical procedures: _____

Is this patient suffering from any other medical condition? ☐ Yes ☐ No

If yes,

i. please state all the other medical condition(s).

ii. kindly advise if the patient was prescribed with any medications to treat his / her medical condition(s)?

Is there any other information, professional or otherwise that you consider should be made known to us?

Please advise period of medical leave given: | Is the patient still under your care for this condition?

_____ Signature of Surgeon / Physician

_____ Name, address and qualification of Surgeon / Physician

Date: _____