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HOSPITAL & SURGICAL CLAIM FORM

The issue of this form is not an admission of liability on the part of the company
All original medical bills & receipts must be submitted with this form to expedite claims handling.

PART 1

A. DETAILS OF POLICY HOLDER/EMPLOYEE/PATIENT

Name Of Policyholder	Policy No. Plan. Date Of Enrolment/Cover
Name of Employee :	Date Of Employment :
Name Of Patient: Relationship of patient to employee : Self / Spouse / Child Occupation of patient:	Sex: Male / Female Marital Status: NRIC/Passport/BC No.: Date Of Birth:
If patient is not employee, please furnish patient's employer's name:	

B. SICKNESS (THIS SECTION MUST BE ANSWERED IN FULL)

Nature Of Sickness	Date First Began : Date First Treated : Date Of Previous Treatment :
Is the sickness due to pregnancy, abortion, sterilisation or infertility? Yes / No / Not Applicable If yes, please specify condition & approximate date of commencement? Date of last pregnancy, if applicable :	
Has The Sickness Been Treated Previously? Yes / No If Yes, Name & Address Of Physician	Did sickness arise from employment? Yes / No

C. INJURY

Date & Time of accident	Is this a job-related accident? Yes / No
Describe the injury, how & when it happened?	

D. OTHER INFORMATION

Name & address of hospital/clinic	
Date admitted : Date discharged : Date surgery performed :	Are you eligible to claim for this insurance against any other insurance policies? Yes / No If Yes, state: 1) insurance company 2) policy no.
Claim cheques shall be made payable to : Employer S$ Employee/patient S$	

MEDICAL INFORMATION AUTHORITY

I hereby authorise any hospital surgeon, medical practitioner or clinic or other person who has attended to me or examined me for any reason, to disclose to Tokio Marine Insurance Singapore Ltd any and all information with respect to any illness or injury and, to provide Tokio Marine Insurance Singapore Ltd copies of all hospital or medical records, including prior medical history. A photostat copy of this authorisation shall be considered as effective and valid as the original.

Employer's signature/Company's stamp/Date

Patient's/Employee's signature/Date

PART 2

(TO BE COMPLETED BY ATTENDING PHYSICIAN)

Name Of Patient	Name Of Employer
Full Description Of Diagnosis	
Is condition due to pregnancy, childbirth, gynaecological problem?	Yes / No, If Yes, please describe fully
If for miscarriage, was it due to accident?	Yes / No, If Yes, please describe fully
Is condition a congenital abnormality or physical defect present at and existing from the time of birth regardless of the time of discovery or treatment? Is it genetic or chromosomal disorder?	Yes / No, If Yes, please describe fully Yes / No, If Yes, please describe fully
Is this a mental or psychiatric condition	Yes / No, If Yes, please describe fully
Is this a venereal disease or sexually transmitted disease?	Yes / No, If Yes, please describe fully
Is this surgery for cosmetic reasons or dental treatment?	Yes / No, If Yes, please describe fully
Is this a job related injury?	Yes / No, If Yes, please describe fully
Has the patient been treated previously for this condition?	Yes / No, If yes, please state when?
Please indicate approximate date from which the patient first noticed symptoms of conditions.	
If this condition existed before symptoms became apparent to the patient, please indicate when in your view this condition began to develop.	
Date you were first consulted for the above condition?	

Medical practitioners, previously consulted by patient.

Name of medical practitioner	Date consulted	Name & Add. Of Clinic
1.		
2.		

Describe surgical procedures or treatments rendered. If no surgery has been performed, please state medication given.	Date surgical procedures or treatments rendered.
Name of Physician/Surgeon/Anaesthetist	In-patient ( ) outpatient ( ) Admission period – from: to:
Is patient still under your care for this condition? Y / N If 'No' give date service terminated.	If patient has been referred to another doctor for follow-up, furnish name and address doctor.

Signature of Physician/Surgeon : _____ Date : _____

Name & Designation : _____

Name & address of clinic/hospital : _____