8801015

Singlife

GROUP MEDICAL INSURANCE CLAIM FORM

Singapore Life Ltd.
Group Life & Health Claims
4 Shenton Way, #01-01 SGX Centre 2
Singapore 068807
Tel: 6827 8030
Company Registration No. 196842419K

SECTION 1 : TO BE COMPLETED BY POLICYHOLDER OR INSURED PERSON

Help us To Serve YOU Better – Contact & Payment Details			
Policy No:	Name of Company:		
Best way to contact you Please Tick ☑ (at least one or both)	☐ Mobile:	☐ Email:	Address of Employee:
Your Bank Details for Direct Credit	Bank Name:	Branch Code:	Bank A/C No:
*Note : Payment will not be made to employee unless prior arrangements was made by your employer with Singapore Life Ltd.			
Type of Claim – Please Tick ☑ (One Claim Per Member)	☐ Inpatient	☐ Outpatient	

About YOU – To Be Completed by Employee				
Name:	NRIC:	Employee ID:		
Gender: ☐ M ☐ F Please Tick	Date of Birth:	Date of Employment:	Occupation:	Nationality:

About YOUR Dependant – Applicable For Dependant Claim ONLY			
Name:	NRIC:	Date of Birth:	
Gender: ☐ M ☐ F Please Tick	Nationality:	Relationship to Employee: Please Tick ☐ Child / ☐ Spouse	Occupation:

Please Tick ☐ **Illness**	Please Tick ☐ **Accident**
Nature of Illness:	Accident Date & Time: Brief Description of Accident:
Nature of Operation (**Applicable if there is surgery performed**):	
Date of FIRST Treatment:	
Name of Referring Doctor (**NOT APPLICABLE for GP Visit**):	
Were you / your dependant hospitalised as a result of an illness or accident? ☐ Yes ☐ No	
Date of Admission:	Date of Discharge:

CONSENT & AUTHORISATION

This part must be signed by the patient's parent / legal guardian if patient is below 21 years old.
I/We 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/We declare that the statements and answers stated are true and complete to the best of my/our 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 (and 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.

_____ Signature of Employee	_____ Signature of Patient (For Dependant)	_____ Date

For Your EMPLOYER (NOT APPLICABLE FOR NAMED BASIS COVER)		
Effective Date of Coverage:	Date of Employment:	Plan:
Company Name & Stamp:	Signature of Employer:	Date of Signature: