ALLIED WORLD
A FAIRFAX Company

MEDICAL CLAIM FORM FOR MAID

SECTION I – PARTICULARS OF POLICYHOLDER/INSURED/EMPLOYER

Name of Insured/Employer: _____

Policy No.: _____

Home Address: _____

Address for Correspondence: _____

Telephone No. (Office): _____ (Home): _____ (Mobile): _____

Email: _____

SECTION II – PARTICULARS OF INSURED PERSON/CLAIMANT/MAID'S PARTICULARS

Name of Insured Person/Maid: _____

Passport No.: _____ Nationality: _____ Date of Birth: DD MM YYYY

Is the treatment/hospital confinement recommended and approved by a legally qualified physician or surgeon? ☐ Yes ☐ No

If yes, please state details of the physician/surgeon

1) Name: _____

2) Address: _____

3) Telephone No. (Office): _____

Is the claimant entitled to claim against Workmen's Compensation Benefits, Employers' Medical Benefits Programme or insurance other than from Allied World Assurance Company, Ltd? ☐ Yes ☐ No

If yes, please provide more details:

Name of Insurer: _____

Policy Number: _____

Please state:

1) Maid's Monthly Wage: _____

2) Maid's Monthly Levy: _____

3) Maid's No. of Working Days in a Month: _____

4) Total Claim Amount: _____

ALLIED WORLD ASSURANCE COMPANY, LTD (SINGAPORE BRANCH)
incorporated in Bermuda with limited liability

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SECTION III – IMPORTANT NOTICE

The issue and acceptance of this form is without prejudice to the terms and conditions of the policy and is not an admission by Allied World Assurance Company, Ltd (Singapore Branch) (collectively with its affiliates "Allied World") of the claim (whether in whole or in part). It should also not be regarded as a waiver by Allied World of any breach by the policyholder or insured of the policy terms and conditions.

To facilitate the processing of the claim, please complete this form as fully and accurately as possible, and return the completed form to Allied World without delay.

The information and documents requested in this form are preliminary only. Further information and documents may be required. Allied World may also request for sight of original documents.

The policyholder and insured must not admit liability, negotiate or settle any third-party claims without the prior written consent of Allied World.

Any communication that the policyholder or insured receives regarding the accident should be sent to Allied World immediately (UNANSWERED).

SECTION IV – DECLARATION, AUTHORISATION & PERSONAL DATA CONSENT

Declaration

I/We:

(i) confirm that I am/we are the policyholder and/or insured;

(ii) declare, to the best of my/our knowledge and belief, and warrant that:

a. all information in this form is true, correct and accurate in every detail; and

b. I/We have not withheld, concealed or suppressed any material information or made a false statement in relation to the claim;

(iii) further agree and undertake that I/we shall not, subsequent to our submission of this form, make any false statement or conceal or suppress any material fact relating to the claim.

Authorisation

I, _____ NRIC/FIN No. _____

hereby consent to and authorise any person or organisation (including the police, any governmental body, medical practitioner, hospital, clinic, insurer) to disclose to Allied World Assurance Company, Ltd (Singapore Branch) (collectively with its affiliates "Allied World") any and all information, records, reports or certifications as Allied World considers, in its absolute discretion, relevant for its assessment of this claim (including any police records, investigation status and results, hospital or medical records/certification including earlier medical history respect to any illness or injury). The information given is true and correct to the best of my knowledge and belief. A copy of this authorization shall be as effective and valid as the original.

Personal Data Consent

I/We acknowledge and consent to Allied World collecting, using, disclosing and processing my/our personal data, including disclosing my/our personal data to third party service providers within or outside Singapore, for the purposes set out in and in accordance with the Allied World Singapore Personal Data Protection Statement available at https://alliedworldinsurance.com/singapore/. If I/we have provided or will provide information to Allied World about any other individuals, I/we confirm that I/we are authorised to disclose his or her personal data and also give this consent on both my/our and their behalf.

Signature of Policyholder / Insured / Date and Company's stamp, if applicable	Signature of Insured Person / Date (18 years old and above)

MEDICAL REPORT

NOTE: This Section must be completed by the Insured Person/Claimant's Attending Physician/Surgeon whose replies should be as full as possible.

SECTION V – TO BE ANSWERED ONLY IF INJURY DUE TO ACCIDENT

1. Date and Time of Accident: DD MM YYYY ☐ am ☐ pm

2. Circumstances and Place of Accident: _____

_____

_____

3. Is injury due to patient's employment? ☐ Yes ☐ No

4. Was the patient under the influence of drugs or intoxicants at the time of accident? ☐ Yes ☐ No

5. Full details of operation performed/surgical procedure:

SECTION VI – TO BE ANSWERED IF DUE TO ILLNESS/SICKNESS

1. Full details of operation performed/surgical procedure:

2. Cause of illness/condition:

3. Date of Admission: DD MM YYYY

   Date of Surgery performed: DD MM YYYY

   Date of Discharge: DD MM YYYY

4. Is the patient still under your care for this illness/condition? ☐ Yes ☐ No

   If No, please provide the date your service was terminated: DD MM YYYY

5. When did the symptoms first appear?

6. When did the patient first consult you for this illness/condition?

7. How long did the patient suffer from this illness/condition before consulting you?

8. In your professional opinion, when do you think patient first suffered from this illness/condition?

9. Was the patient referred to you? If so, please provide name and address of referring doctor:

10. What is your diagnosis of this illness?

a) Primary: _____

b) Secondary: _____

c) Others: _____

11. What is your prognosis of the illness?

12. Is this illness/condition likely to recur?

13. Was the patient's illness/condition a congenital anomaly?

14. Was patient's illness/condition related to pregnancy, miscarriage, abortion, sterilisation, infertility or childbirth?
If yes, please specify condition and approximate date of commencement:

15. Was the patient's illness/condition due to self-destruction or intentional self-inflicted injury?

16. Was the patient's illness/condition a mental or nervous disorder?

17. Was this surgery for cosmetic reasons or dental treatment or an elective surgery?

18. Has the patient previously been treated for this illness/condition or any other serious disorder? If yes, please state:

Date (DD/MM/YYYY)	**Diagnosis & Date of Diagnosis**	**Details of treatment**	**Name of Doctor/Hospital**

I hereby certify that the foregoing statement are correct.

Name and qualification of Doctor: _____

Name and Address of Hospital/Clinic: _____

Tel No.: _____ Fax No.: _____

Signature of Doctor/Date: