Maid Insurance

CLAIM FORM

Singlife

SECTION A: EMPLOYER/CLAIMANT DETAILS (Please attach a copy of the claimant's work permit)

Policy Number

Policyholder/Employer Name

Policyholder Address

Policyholder NRIC

Policyholder Date of Birth

Contact Number

Email Address

Monthly Levy (SGD)

Claimant/Maid Name

Work Permit Number

Nationality

Date of Birth

SECTION B: INCIDENT DETAILS

Date and time of loss/accident/injury

Location of loss/accident/injury

Detailed description of loss/accident/injury (Chronology of events - Please attach additional pieces of paper if necessary)

Are you covered for this loss/accident by any other insurance policies? ☐ Yes ☐ No

Did this loss/accident/injury occur whilst on the job? ☐ Yes ☐ No

If Yes, please give details of insurer, policy number and amount recoverable.

SECTION C: SICKNESS OR INJURY DETAILS

Details of sickness or injury (e.g. which body part (chin, elbow, ankle, etc) and nature of injury (fracture, cut, bruise, etc).

Date first began

Date first treated

Date of last treatment

Have you ever suffered from this injury/illness or a similar condition before? ☐ Yes ☐ No

Maid Insurance

CLAIM FORM

SECTION D: DECLARATION AND AUTHORISATION

☐ I declare that the information provided is, to the best of my knowledge, correct in every detail. I agree that if I have made any false or fraudulent statements or suppress, conceal or falsely state any material facts whatsoever, either now, or in the future, with regard to this claim, the Policy shall be void and all rights of recovery in respect of past or future claims, shall be forfeited.

☐ 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) disclosing and 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 Notice which may be found at https://singlife.com/en/pdpa. Singlife's Data Protection Notice 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.

☐ I hereby authorise any hospital physician, other person, who has attended or examined me, to furnish Singapore Life Ltd. (referred to as "Singlife"), or its authorised representatives, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

Signature of Authorised Person & Company Stamp:	Signature of Claimant:

Name of employer

Name of patient

☐☐ / ☐☐ / ☐☐☐☐

Date (DD / MM / YYYY)

Maid Insurance

PHYSICIAN'S STATEMENT

Attending Physician's Statement (to be completed by attending physician)

SECTION E: PATIENT'S MEDICAL RECORDS

Name of Patient

When did you first see the Patient? (dd/mm/yyyy) Was the Patient referred to you? ☐ Yes ☐ No

Name and address of doctor who made the referral

SECTION F: SICKNESS OR INJURY DETAILS

Is it due to sickness or injury? ☐ Injury ☐ Sickness

Is this a job-related injury? ☐ Yes ☐ No

If it is due to an accident, please state the date and time of accident (dd/mm/yyyy) (hh:mm)

Was the Patient under the influence of drugs or intoxicants at the time of accident? ☐ Yes ☐ No

Details of symptoms(s) presented during the consultation (if treatment is due to injury, please provide details on nature and extent of injuries sustained)

What is the underlying cause of illness/injury?

Exact Diagnosis

a. Primary

b. Secondary

c. Others

Describe surgical procedures or treatments rendered. If no surgery has been performed, please state medication given.

Date of Admission

Date of Surgery Perfomed

Date of Discharge

In your professional opinion, when do you think the patient first suffered from this illness?

Maid Insurance

PHYSICIAN'S STATEMENT

Attending Physician's Statement (To be completed by attending physician)

SECTION F: SICKNESS OR INJURY DETAILS (continued)

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

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

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

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

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

Has the patient previously been treated for this illness/condition or any other serious disorder? ☐ Yes ☐ No

If **Yes**, please state:

Date	Diagnosis	Details of Treatment	Name of Doctor/Hospital

Is the patient still under your care for this condition? ☐ Yes ☐ No

If **No**, indicate the date your service was terminated

SECTION G: DECLARATION

I hereby declare that the above answers are true to the best of my knowledge and belief.

Signature of Doctor/Address & Official Stamp of Doctor:

Name of Doctor

Date ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

Designation

Name & Address of Hospital/Clinic