TOKIO MARINE

Tokio Marine Insurance Singapore Ltd.
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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 Fire & GA Claims Dept Fax: 6225 9887

PART 1

Email:

A. DETAILS OF POLICY HOLDER/ PATIENT

Name Of Employer : NRIC / Passport No: Address:	Policy No : Plan. : Contact No : Monthly Levy : S$
Name Of Patient (Domestic Servant) : Nationality : Date Of Birth :	Sex : Male / Female Marital Status : Work Permit No : Please attach a copy of work permit

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

Nature Of Sickness (Please provide details of illness [including description of symptoms] and attach hospital discharge summary for our reference. For female who was pregnant at time of hospitalisation, please state the number of months of pregnancy.)	Date First Began : Date First Treated : Date Of Previous Treatment : Was Sickness 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 : Cheque payable to:	Are you eligible to claim for this insurance against any other insurance policies? Yes / No If Yes, state: 1) insurance company 2) policy no.

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.

Notice for Personal Data Protection Policy

By signing this Form:

i. I/We acknowledge and consent to TMiS collecting, using, processing and disclosing to third party service providers, or intermediaries, within or outside Singapore, my/our personal data for the purpose of processing/servicing my/our policies/claims;

ii. I/We declare and confirm that I/we have obtained the consent of the person(s) and/or nominee(s) named herein, where applicable, and that he/she/they has/have authorized me/us to disclose their personal data and to give consent on their behalf for the above collection, use, process and disclosure; and

iii. I/We acknowledge the detailed Privacy Policy Statement, governing the above, posted at www.tokiomarine.com.sg.

Employer's Name/Signature/Company's stamp/Date

Patient's Name/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.

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Signature of Physician/Surgeon : _____ Date : _____

Name & Designation : _____

Name & address of clinic/hospital : _____