Liberty Insurance

www.libertyinsurance.com.sg

Claim Form

Group Hospital & Surgical Student Medical Insurance

Please complete all sections to facilitate the processing of your application. This form is issued without admission of liability and it must be completed and returned to us immediately, whether or not a claim is made. Any documentary proof or report required by Liberty shall be furnished at the expense of Policyholder or Claimant.

Please submit the following documents within 30 days from the date of discharge from hospital.

For hospitalization in Government/Restructured Hospital

1. Duly completed and signed claim form (Page 2) and a copy of student pass
2. All original final hospital bills, doctor's/specialist's bills and receipts
3. Inpatient Discharge Summary
4. Inpatient Admission Report (if available)
5. Day Surgery Admission Report (if available)

For hospitalization in Private Hospital/Hospital outside Singapore

1. Duly completed and signed claim form (Page 2) and a copy of student pass
2. All original final hospital bills, doctor's/specialist's bills and receipts
3. Medical Report from attending physician/specialist (page 3)
4. Inpatient Admission Report (if available)
5. Day Surgery Admission Report (if available)

Please submit the completed documents to:
SINGAPORE POST CENTRE P.O. BOX 15 Singapore 914001 (Student Medical Insurance Claim)

For Claim information and enquiries, please contact:

Ms Christina Chng @ 9760 2569
Email: info@enrichadvisory.com

Ms Genna Ang @ 9671 5922
Email: genna@enrichadvisory.com

Information of Policyholder

Name of Private Education Institution (PEI):	**Policy No.:**
ASCENSIA ACAEMY PTE LTD	SD16M03846 (2017)

Information of Student Details

Name of Student:		**Gender:** ❑ Male ❑ Female
NRIC/FIN No.:	**Date of Birth:**	**Contact No.:**
Mailing Address:		Postal Code ( )
Email Address:		**Course Start Date:**
State nature of illness & date upon which symptoms first occurred:		**Plan No.:** N.A
Did you seek medical treatment prior to being diagnosed with the illness for which you are claiming now? If Yes, please state the name of insurer and policy no.		❑ Yes ❑ No
Are you claiming from any other insurer in respect of this illness/injury? If Yes, please state the name of insurer and policy no.		❑ Yes ❑ No

Type of Accident

How did the accident happen? _____	**Road-related**	❑ Yes ❑ No
	Work-related	❑ Yes ❑ No
	Others	❑ Yes ❑ No
Describe the nature of injuries sustained: _____		
Date & Time of Accident: _____	**Place of Accident:** _____	

Claims Payment Details

Claim amount to be made payable to:	❑ Private education institution/school ❑ Student CHEQUE TO BE CROSSED ? ( ) YES ( ) NO

All check payments and claim documents will be delivered to the private institution/school.

PERSONAL DATA PROTECTION

By providing your personal data to Liberty Insurance Pte Ltd, you agree and consent to allow Liberty Insurance Pte Ltd and its employees, related companies, agents and service providers to collect, use, disclose, transfer and process your personal data for one or more of the purposes described in Liberty Insurance Pte Ltd's Data Protection Policy including but not limited to underwriting, processing and administering your policy and contractual relationship with us; premium collection, settlement of claims; carrying out your instruction and responding to your enquiries. The full Data Protection Policy can be found at www.libertyinsurance.com.sg/data-protection-policy/

DECLARATION

I declare that I have complied with the conditions and warranties (if any) of the Policy and in no manner deliberately caused the said loss or damage or exaggerated the claim or sought unjustly to benefit by any fraud or willful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty Insurance reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.

I authorize the release of any medical information necessary to process this claim.

_____
Student's signature

Date:

_____
Name of PEI Administrator & signature

PEI's Stamp:

Date:

Medical Information (to be completed by the attending physician*)

Name of Patient: _____

NRIC/FIN No.: _____

Date when the patient first consulted you: _____

Prior to the first consultation with you, when did the patient first suffer the symptoms of the condition: _____

Presenting complaints: _____

Duration of illness/injuries at time of consultation: _____

Was the Patient referred by another physician? ❑ Yes ❑ No

If Yes, please provide details:

Name of Physician: _____ Address: _____ Contact No.: _____

State your diagnosis of the illness/injuries: _____

Investigations Done

Blood Test ❑ Yes ❑ No Others, please specify: _____

X-Ray ❑ Yes ❑ No

If Yes, please furnish copies of the reports/investigation results

Type of surgical operation(s) done: _____

Date of Admission: _____ **Date of Discharge:** _____

Is there any connection between the present condition and any other pre-existing illness or previous accident? ❑ Yes ❑ No

If Yes, please provide details: _____

Is the condition of the patient:

Congenital in nature	❑ Yes	❑ No	Sexually transmitted disease	❑ Yes	❑ No
Genetic or chromosomal disorder	❑ Yes	❑ No	Related to cosmetic treatment	❑ Yes	❑ No
Mental/psychiatric disorder	❑ Yes	❑ No	Infertility related	❑ Yes	❑ No
Drug addiction/alcoholism	❑ Yes	❑ No	Treatment of teeth/gum tissue/oral cavity	❑ Yes	❑ No
Self-inflicted injury	❑ Yes	❑ No	Pregnancy related	❑ Yes	❑ No

If any of the above is Yes, please provide details: _____

Will illness/injury require further follow-up treatment ❑ Yes ❑ No

If Yes, please provide details: _____

Any other relevant information: _____

I hereby certify that I have personally examined and treated the patient for the above illness/injuries and that the facts are given above present my opinion of the patient's condition.

Date _____

Signature of Physician _____

Name of Physician:

Contact No.:

Company Stamp: