Sompo Insurance Singapore Pte. Ltd.
50 Raffles Place, #05-01/06 Singapore Land Tower, Singapore 048623
Tel: 6461 6555 | Fax: 6221 3302 | Website: www.sompo.com.sg
Co. Reg. No.: 198905490E | GST Reg. No.: M200903196

Medical Certificate of Treatment (Personal Accident) Form

This form is to be completed by the Claimant's Medical Attendant whose replies should be as full as possible. No claim can be admitted unless a medical certificate is furnished at the expense of the claimant.

Medical Information Authority Policy / Certificate No _____

I hereby authorize any hospital surgeon, medical practitioner or clinic or other person who has attended to me or examined me with respect to the below mentioned injury or sickness, to disclose to **Sompo Insurance Singapore Pte. Ltd.** any and all information with respect to the injury or illness and, to provide to **Sompo Insurance Singapore Pte. Ltd.** copies of all hospital or medical records, including prior medical history.

_____ _____
Employer's Signature/Company's Stamp/Date Claimant's/Employee's Signature/Date

_____ _____
Name Name

1. **Name of Patient :** _____
2. **Name of Employee / Member's Company :** _____
3. **Name of Medical Establishment :** _____
4. **Nature of Admission :** Out-patient ☐ In-patient ☐ Day Surgery ☐
5. **Period of Admission :** _____ To _____
6. **State Nature and Extent of Injury :**

_____
_____
_____
_____
_____
_____
_____

7. **What is the cause of injury? Are the symptoms from which he suffers due to:**
   (i) the accident alone? Yes ☐ No ☐
   (ii) or are they traceable to any other cause? Yes ☐ No ☐ If yes, please give details

_____
_____

8. **Have you any reason to think the Claimant was otherwise than perfectly sober at the time of accident?**
   Yes ☐ No ☐

9. Are you aware of anything in his previous medical history which has contributed, directly or indirectly, to the occurrence of the accident, or which may be likely to retard in any way his recovery from it?

Yes ☐ No ☐ If yes, please give details

_____

_____

10. How long has the Claimant been unable to attend to his usual profession or occupation as a result of the accident referred to above?

Unfit for duty From _____ To _____

Fir for light duty From _____ To _____

11. Is the claimant still unable to attend to his usual profession or occupation as a result of the accident?

Yes ☐ No ☐

If yes, please give approximate length of time the claimant will continue to be unable to attend to his usual profession or occupation.

Unfit for duty From _____ To _____

Fir for light duty From _____ To _____

12. Has any permanent disability been suffered? Yes ☐ No ☐

If yes, please state nature and percentage of disability suffered.

_____

_____

13. Was the claimant suffering from any existing physical defect or illness at the time of the accident?

Yes ☐ No ☐ If yes, please state nature and percentage of disability suffered.

_____

_____

14. Describe surgical procedures or treatment rendered (include name and dosage if medication was given).

_____

15. Date surgical procedures or treatment was rendered : _____

16. Is surgery for cosmetic reason? **Yes** ☐ **No** ☐

17. Is surgery medically necessary? **Yes** ☐ **No** ☐

18. Is patient still under your care for this condition? **Yes** ☐ **No** ☐

If yes, state nature of treatment, If no, give date your service terminated _____

_____

_____

_____

_____ _____

Signature of Doctor/Surgeon Name and Address of Clinic/Hospital (with chop)

_____ _____

Name and Title Date

Please forward this form to **Sompo Insurance Singapore Pte. Ltd.**
Claims Department
50 Raffles Place
#05-01/06 Singapore Land Tower
Singapore 048623