Sompo Insurance Singapore Pte. Ltd.
UEN: 198905490E
GST Reg No: M200903196

Foreign Worker Medical Claim Form

Important Notice

1. The acceptance of this form is NOT an admission of liability on the part of the Company.
2. Do retain the original final bills and supporting documents for 6 months after claims submission as we may request for them.
3. All medical reports must be submitted at the claimant's expense before a claim can be admitted.
4. Please answer in full all applicable questions as incomplete answers may delay claims settlement

What documents do I need to submit?

- Fully completed claim form
- Medical reports and / or In-Patient Discharge Summary Form
- Medical bills and final hospital bills
- Worker's Work Permit Card or Identity Card

Useful notes

- Please ensure that the hospital bill submitted is the **Final** bill. An interim bill will not give an accurate figure for the hospitalization bill and we will not be able to make payment based on the interim bill.
- **In-patient Discharge Summary** (IDS) should be provided as this will give an indication of the medical condition sustained.
- If the information on the IDS is not sufficient we may request for additional information and / or the Medical Certification form to be completed by the attending doctor. The cost of any medical report will be borne by the insured.

Agency: _____ **Policy No: _____**

1. INSURED'S PARTICULARS

a. Name of Employer / Insured:

_____

b. Address:

_____

c. Contact Person / Contact Nos.:

Contact person: _____ (O) _____ (HP) _____

2. EMPLOYEE'S PARTICULARS

a. Name of Employee:

_____

NRIC / FIN No. of Employee: _____ Nationality: _____

b. ☐ Female ☐ Male / Age: _____ Date of birth: _____ / Contact No: _____

c. State Employee's date of employment and occupation:

Date: _____ Occupation: _____

3. DETAILS OF ILLNESS / INJURY

a. Describe what happened (if insufficient space, please attach statement):

_____

_____

b. Nature of Illness (describe symptoms suffered) / Injury (eg. fracture, cut, bruise etc.):

_____

_____

c. When did symptoms first start/Date of Accident: _____ First treatment: _____

d. Date of In-patient Admission or Day Surgery: _____

e. Are you still being treated? ☐ Yes ☐ No

f. Any more bills to be submitted? ☐ Yes ☐ No

g. Have you consulted a doctor or been treated for any similar condition in the past? ☐ Yes ☐ No

If yes, kindly give more details including date of previous treatment and name and address of attending doctor for previous treatment.

_____

_____

h. Is the injury work-related: ☐ Yes ☐ No

4. PAYMENT DETAILS

Please confirm payee name if claim is payable: _____

We may request for your doctor to complete the Medical Certificate of Treatment Form if more information on the medical condition is required.

Declaration and Authorization – To be signed by the claimant

We/I hereby declare that the above statements are true, accurate and complete and I understand that if I have in this or in any further declaration in respect of this claim, made any false or fraudulent statement or suppress conceal or falsely state any material fact whatsoever my claim may be refused. We/I undertake to advise the Company promptly of all developments in connection with the claim and to render every assistance in dealing with the matter. I/We further authorize the Company to treat the submission of this form as my/our making a claim under my/our policy.

I acknowledge and agree (in case of corporate policy, I represent that I have obtained the consent of the individuals in relation to this policy) that Sompo may collect, use, disclose and/or process my personal data (in case of corporate policy, personal data of individuals in relation to this policy) in accordance with the Personal Data Protection Act 2012 for the purposes and uses described in Sompo's Privacy Policy (including the provision of protection, services related to this insurance policy, screening activities in accordance with legal/regulatory obligations/risk management procedures). This may include disclosure to Sompo's business partners, intermediaries, third party service providers and industry associations. Sompo's Privacy Policy can be found at www.sompo.com.sg

_____ _____

Signature of Employee Date

_____ _____

Authorized signature and Insured's Company Stamp Date