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Co. Reg. No.: 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 All original final bills, certificates, supporting documents should be provided to substantiate your claim.
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
- Original medical bills and final hospital bills

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.
- At the minimum you should provide the **In-patient Discharge Summary** 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 Insured

_____

b. Address

_____

c. Contact Nos. / Contact person

Contact person _____ (O) _____ (HP) _____

2. WORKER'S PARTICULARS – please attach copy of the worker's passport and work permit or identity card

a. Name of worker

_____

NRIC / Passport No. of Claimant: _____ Nationality _____

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

c. State worker'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. Are you still being treated? ☐ Yes ☐ No

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

f. 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.

_____

_____

g. Is 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 Authorisation – 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 authorise 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 Worker Date

_____ _____

Authorized signature and chop of Insured Date