SOMPO

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

Group Hospital & Surgical 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

Agency _____ **Policy No.** _____ **Plan** _____

1. INSURED'S PARTICULARS (TO BE COMPLETED BY EMPLOYER/POLICYHOLDER)

a. Name of Employer/Policyholder

_____

b. Address

_____

c. Contact No. (O) _____ (HP) _____ (F) _____

d. GST Registered? ☐ Yes, GST Registration no. _____ ☐ No

e. If you are GST-registered, are you allowed under regulations 26 & 27 of the GST (General) Regulations to claim input tax incurred on the insurance premiums? ☐ Yes ☐ No

2. CLAIMANT'S PARTICULARS (TO BE COMPLETED BY EMPLOYEE/CLAIMANT)

a. Name of Employee and Name of Claimant ☐ Tick if Foreign Worker (To attach copy of work permit)

_____

☐ Employee ☐ Dependent of Employee

If Employee, state date of employment, occupation and department

Date _____ Occupation _____ Department _____

If Dependent, state relationship to Employee ☐ Husband / Wife ☐ Son ☐ Daughter ☐ Parent

b. ☐ Female ☐ Male / Age: _____ Date of birth: _____ / ☐ Married ☐ Single

c. Address of Claimant _____

d. NRIC / Fin No. of Claimant _____

e. Name of Usual/Family Doctor/General Practitioner _____

Address _____ Contact No. _____

f. Any other Insurance covering this claim? ☐ Yes ☐ No

If Yes, give the name of Insurer(s) & policy no. _____ (Please tick ☐ Group ☐ Individual)

g. Nature of sickness/Injury _____

i. Any previous claim in respect of this Employee/Claimant under this policy? ☐ Yes ☐ No

3. MEDICAL INFORMATION AUTHORITY (MUST BE COMPLETED BY EMPLOYEE/CLAIMANT)
(To be completed by Employee if Claimant is a minor)

I,_____.NRIC NO _____hereby authorize any hospital, surgeon, medical practitioner, clinic, insurance office or other person or organization who has attended to me/for any reason, to disclose to **Sompo Insurance Singapore Pte. Ltd.** any and all information with respect to any illness or injury and to provide copies of all hospital or medical records/certificate, including earlier medical history. A photocopy of this authorization shall be considered as effective and valid as original.

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

The information given is true and correct to the best of my knowledge and belief.

_____	_____
Claimant's Signature	Employer's/Policyholder's Signature (if Corporate – Employer's Signature & Company's Stamp)
Date:	Date: