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Co. Reg. No.: 198905490E | GST Reg. No.: M200903196

Hospital and Surgical 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.

Agency _____ **Policy No:** _____

1. INSURED'S PARTICULARS

a. Name of Insured

_____

b. Address

_____

c. Contact Nos.

(Res) _____ (O) _____ (HP) _____

2. CLAIMANT'S PARTICULARS

a. Name and nature of relationship of Claimant to Insured

_____

☐ Insured ☐ Dependant of Insured ☐ Employee ☐ Dependant of Employee

NRIC / Passport No. of Claimant: _____

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

c. If Dependant state relationship to Insured / Employee

☐ Husband / Wife ☐ Son ☐ Daughter ☐ Parent

d. Is Dependant employed? ☐ No ☐ Yes Occupation :_____

e. If Employee, state date of employment and occupation

Date: _____ Occupation: _____

3. DETAILS OF ILLNESS / INJURY

a. Please state exactly what happened (if insufficient space, please attach statement).

_____

_____

_____

_____

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

_____

_____

_____

c. Date symptoms first commenced / Date of Accident: _____

Date condition was first treated: _____

d. Is illness still being treated?

☐ Yes. State nature of ongoing treatment and approximate date of completion.

_____

☐ No. State date of last treatment or appointment. _____

e. Has the claimant even seen a doctor or been treated for any similar condition in the past? ☐ Yes ☐ No

If yes, state date of previous treatment and name and address of attending doctor for previous treatment.

_____

f. Is injury work related: ☐ Yes ☐ No

4. GENERAL INFORMATION

a. Name and Address of Regular Physician if different from Attending Physician.

_____

_____

b. Are you entitled to receive compensation from any other source for this illness / injury? ☐ Yes ☐ No

If yes, state: From what source : _____

To what extent : _____

c. Have you ever made a claim for compensation in respect of illness or accidental injury from any Insurance Company?

☐ Yes ☐ No If yes, give particulars.

_____

5. PAYMENT DETAILS

a. Please confirm payee name if claim is payable _____

Kindly arrange for your doctor to complete the Medical Certificate of Treatment Form.

Declaration and Authorisation – To be signed by 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 Claimant Date

(Affix Company stamp if applicable)