LONPAC INSURANCE (S98FC5635C)

DOMESTIC MAID INSURANCE MEDICAL CLAIM FORM

To help us expedite your claim, please complete this form (including Attending Doctor's Statement) fully and return together with a copy of the Certificate of Insurance, a copy of the maid's work permit, a copy of the employment contract, original medical invoices, receipts and discharge summary within 30 days of discharge from the hospital.

Part I – To be completed by Employer and Patient (Maid)

PARTICULARS OF INSURED	
Name of Employer	NRIC / Passport No.
Policy No. / Insurance Certificate No.	Contact Person / Telephone No.
Address	

PARTICULARS OF PATIENT (MAID)

Name of patient (Maid)		Date of employment	
Marital status	Nationality	Date of birth	Sex

MEDICAL CONDITION OF PATIENT (MAID)

Illness (Please provide details of illness [including description of symptoms] and attach hospital discharge summary for our reference. For female who was pregnant at time of hospitalisation, please state the number of months of pregnancy.)		Accident (Please provide details on extent of injury & circumstances of the accident. Please also attach accident report.)	
Date which symptoms first appeared	Duration of symptoms	Date of accident	Time of accident
Name and Address of attending Doctor		Did you have any surgical operation due to this illness/ Accident?	If yes, when was the operation? (DD/MM/YYYY)
Name and Address of referral Doctor / any other Doctor consulted		Name and address of regular Doctor	

OTHERS

Please advise the amount of government levy that the Insured (employer) pays monthly.
Are you entitled to or claiming reimbursement from any Insurance Company? If yes, please provide the following information: Name of Insurance Company Policy Number Claim Amount

DATA PRIVACY STATEMENT

In accordance with the Personal Data Protection Act 2012, I/We consent to the collection, use, disclosure of and/or process my/our personal data (whether contained in the Claim Form or otherwise obtained) by Lonpac Insurance Bhd ("Lonpac"), its affiliates and service providers (within or outside Singapore), for the purpose relating to the evaluation of the claim and to provide advice and information relating to the claim to me/us by Short Message Service (SMS), Multimedia Messaging Service (MMS) and fax messages (notwithstanding the registration of my/our telephone number(s) in the Singapore's Do Not Call Registry).
For more information on our Privacy Policy, please visit our website http://www.lonpac.com.sg/web/sg/privacy_policy.

I/we have read and agreed to the above Data Privacy Statement.

_____ Signature of Patient (Maid)	_____ Signature of Employer
_____ Name:	_____ Name:
_____ NRIC / Passport No.	_____ NRIC / Passport No.
_____ Date:	_____ Date:

DECLARATION / AUTHORISATION

I hereby declare that the above statements are true and complete to the best of my knowledge. I give consent to Lonpac Insurance Bhd to seek information from any doctor, hospital or organization and authorize the provision of such information. A photocopy of this authorization shall be treated as a valid document. Signature of Patient (Maid): Date:
I hereby declare that the foregoing particulars are true and correct. Signature of Employer Date:

ATTENDING DOCTOR'S STATEMENT

THIS ATTENDING DOCTOR'S STATEMENT IS TO BE COMPLETED AT THE CLAIMANT'S EXPENSE IN ACCORDANCE WITH CONDITION 6C OF THE POLICY.

Part II (To be completed by attending Doctor / Surgeon)

Name of patient		NRIC / Passport No.	Date of Birth
Name of hospital (admission)		Admission date	Date of Discharge
Dates of first consultation and subsequent consultations		Symptoms presented by patient	
Did the patient have any symptoms prior to consulting you? If yes, please specify the date which the symptoms first started prior to the date of first consultation with you. ☐ Yes: Date _____ ☐ No ☐ Not to my knowledge		How long has the illness/ injury been existing prior to the date of first consultation with you?	
Has patient ever had the same or similar condition? ☐ Yes ☐ No ☐ Not to my knowledge	What is the cause of illness/injury?	Date of diagnosis	Diagnosis of illness or extent of injury
Treatment (s) provided		Surgery performed _____ _____ _____	Surgery Date (DD/MM/YY) ____/____/____ ____/____/____ ____/____/____
Please provide Name and Address of the Doctor(s) who had treated the patient previously or referred patient to you.			

Was the condition of the patient due to the following (please tick):	Yes	No	(If 'Yes', please provide details.)
Congenital anomaly or genetic defects present at birth……	☐	☐	
Study and treatment of sleeping order……..…	☐	☐	
Dental treatment……	☐	☐	
Sexually Transmitted disease……	☐	☐	
AIDS or HIV infection……	☐	☐	
Functional disorder of the mind or nervous mental disorder……..	☐	☐	
Alcoholism……..	☐	☐	
Drug addiction……	☐	☐	
Cosmetic or plastic surgery……	☐	☐	
Pregnancy, child birth, infertility or sub-fertility, miscarriage, abortion……..	☐	☐	
Self inflicted injuries……..	☐	☐	

Signature & Stamp of Doctor		Name and address of practicing clinic
Name of Doctor	Date	

Updated : 10 Apr 2017

Lonpac Insurance Bhd
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