ERGO

HOSPITALIZATION & SURGICAL CLAIM FORM

The insured is required to state as fully and accurately as possible the information asked for the hereunder and to return this form immediately to the Company. The acceptance of this Form is not in itself an admission of liability on the part of the Company.

PART I - STATEMENT BY PATIENT AND EMPLOYEE

1 (a) Patient's Name ____________________

(b) Sex ☐ Male ☐ Female (c) Date of birth ____________

(d) NRIC/Fin No./Passport No. ____________________

(e) Patient's relationship to employee ____________________

2 If Patient is not the Employee, please complete:

(a) Employee's Name ____________________

(b) Sex ☐ Male ☐ Female (c) Date of birth ____________

(d) NRIC/Fin No./Passport No. ____________________

(e) Did sickness/accident arise from employment ☐ Yes ☐ No

(f) Patient's Employer (if any) ____________________

3 SICKNESS

(a) Nature of sickness ____________________

(b) Date of sickness first begin ____________ (c) Date first treated ____________

(d) Was this condition treated previously? ☐ Yes ☐ No (e) Name of Doctor ____________

(f) Address of Doctor ____________________

(g) Did this doctor refer you on his own accord to the Specialist who is now treating you? ☐ Yes ☐ No
If Yes, please attach Doctor's referral letter.

4 ACCIDENT

(a) Date of accident ____________ (b) Time ____________

(c) Describe how and where accident happen

____

____

____

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5 OTHER INSURANCE

(a) Is the Patient entitled to claim against Workmen's Compensation Benefits or other Medical Benefits?

☐ Yes ☐ No

If Yes, please state Insurance Company ____

I certified that the above statement and answers are true and complete to the best of my knowledge and belief.

I hereby authorize any hospital, clinic, physician or any other person to disclose all information including copies of all hospital or medical records on the patient when requested by ERGO Insurance Pte. Ltd.. With respect to any illness, injury, consultations, medical history, prescriptions or treatment.

A photostat copy of this authorization shall be considered effective and valid as the original.

Signature of Patient ____________________

Date ____________________ Signature of Employee ____________________

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PART II - STATEMENT BY EMPLOYER

1 Name of Employer ______________________

2 (a) Name of Employee ______________________

(b) Certificate No. ______________________

(c) Present Occupation ______________________

(d) Date of Employment ______________________

(e) Benefit Catergory ______________ (e.g. Exempt, Non Exempt, Managerial, Executive etc)

3 (a) Effective date of Employee's medical insurance ____________ (b) Plan Type. ____________

4 If Patient is the spouse or child, please complete:

(a) Effective date of dependant's coverage ____________ (b) Plan Type. ____________

For and on behalf of the Employer

______________________ Name

______________________ Signature/Company's Stamp

______________________ Designation

______________________ Date

Cheque payable to | Amount(S$)

1 CPF Medisave A/C No. ______________ ______________

2 ______________ ______________

3 ______________ ______________

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PART III - MEDICAL REPORT BY ATTENDING PHYSICIAN/SURGEON
PLEASE COMPLETE THIS FORM AND RETURN TO ERGO INSURANCE PTE. LTD.

Name of Patient ____________________

Age ____________ Sex ☐ Male ☐ Female

1 (a) Nature of sickness or injury (if fracture or dislocation, describe nature and location)

____

(b) Is condition a congenital anomaly, nervous or mental disorder? ☐ Yes ☐ No
If Yes, explain.

____

(c) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No
If Yes, explain.

____

(d) Is condition due to Pregnancy or Infertility or Childbirth? ☐ Yes ☐ No
If Yes, what was the approximate date of commencement of pregnancy?

____

2 (a) Has Patient had same or similar condition? ☐ Yes ☐ No

____

(b) When did symptoms first appear or accident happen? ____________________

(c) When did Patient first consult you for this condition? ____________________

3 (a) Nature of surgical or obstetrical procedure (if any) (Describe fully)

____

(b) Date of operation. ____________________

4 Give dates of other medical (non-surgical) treatment. (if any) ____________________

5 What other services, if any, did you provide patient? (itemize giving dates and fees) ____________________

____

6 Is patient still under your care for this condition? ☐ Yes ☐ No

If No, give date your services terminated ____________________

7 Name of physician previously consulted by patient ____________________

____________	____________	____________	____________
Date	Signature (Physician/Surgeon)	Qualification	Telephone

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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 ERGO Insurance Pte Ltd, 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 Mail, Email and fax messages (notwithstanding the registration of my/our telephone number(s) in the Singapore's Do Not Call Registry).

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

Signature ____________________________

Name ____________________________

NRIC/Passport No. ____________________________

DECLARATION AND AUTHORIZATION

I/We hereby declared the foregoing answers to be true and correct in every respect to the best of knowledge and no information or particulars have been suppressed.

Signature of Insured(with company stamp)

Date (dd/mm/yyyy)

ERGO Insurance Pte. Ltd. Co.Reg.No.:199305211H
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