MSIG Insurance (Singapore) Pte. Ltd.
4 Shenton Way #21-01 SGX Centre 2 Singapore 068807
Claim Hotline: (65) 6827 7660 (24 hours) Fax: (65) 6225 6371
Co. Reg. No. 200412212G

Maid Insurance Claim Form

Policy Number	

Please note that this form is issued without admission of liability. Please state all relevant information requested as complete and as accurate as possible.

Particulars of Insured / Insured Person

Name of Employer (the Insured)			NRIC Number
Address			
Contact Number (H)	(O)	(HP)	Email
Name of Maid (the Insured Person)			Work Permit Number
Monthly Wage	Monthly Levy		Date of Employment (dd/mm/yyyy)

Injury

Date of Accident (dd/mm/yyyy)	Time of Accident ❑ am ❑ pm	Place of Accident
Describe in detail extent of injury and how accident happened (please provide Police Report, if any)		

Sickness

Nature of Sickness	Date Symptom First Began (dd/mm/yyyy)	Date First Treated (dd/mm/yyyy)

Is the sickness due to pregnancy, abortion, sterilization or infertility? ❑ Yes ❑ No
If Yes, please specify condition:
Date of commencement:

Has the sickness been treated previously? ❑ Yes ❑ No
If Yes, please state Name and Address of the Physician:
Date of previous treatment:

Other Information

Name of Hospital / Clinic	Name of Attending Doctor
Address of Hospital (if outside Singapore)	

Date of Admission (dd/mm/yyyy)	Date of Surgery Performed (dd/mm/yyyy)	Date of Discharge (dd/mm/yyyy)

OTHER INSURANCE OR COMPENSATION

Is the maid entitled to claim against any other insurance policies? ❑ Yes ❑ No
If Yes, please state Name of Insurance Company, Policy Number and amount you are entitled to claim:

Supporting Documents

1. Original bills 2. Copy of Discharge Summary 3. Copy of Work Permit

Medical Authorization (This portion must be completed by the Insured Person)

I hereby authorize any hospital physician or other person who has attended or examined me to furnish to the Insurer or its representative any and all information on my illness, injury, medical history, consultations, prescriptions or treatment, with copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Maid (Insured Person) Name of Maid (Insured Person)

Declaration

I declare that the information given is true and correct to the best of my knowledge and belief. I understand that any false or fraudulent statements or any attempt to suppress or conceal any material facts shall render the policy void and I shall forfeit my rights to claim under the policy.

Signature of Employer (Insured) Name of Employer (Insured) Date

MEDICAL REPORT

The Claimant must obtain at his/her own expense the medical report from his/her Medical Attendant.

TO BE COMPLETED BY ATTENDING PHYSICIAN / SURGEON

Name of Patient	NRIC/Passport
Admission Period	Date sickness / injury was first diagnosed
Final Diagnosis (Based on ICD, 1975 Revision, WHO) of sickness* or extent of injury	ICD Code

What is the cause of the sickness / injury?

Is Patient under the influence of intoxicant at the time of admission? ❑ Yes ❑ No

Is the condition/treatment related to:		If Yes, please elaborate
Pregnancy or childbirth, abortion or miscarriage, infertility or sub-fertility condition?	❑ Yes ❑ No	
Congenital Anomaly, Genetic or Chromosomal Disorder?	❑ Yes ❑ No	
Mental or Psychiatric Condition?	❑ Yes ❑ No	
Cosmetic Surgery?	❑ Yes ❑ No	

How long had the patient been troubled by symptoms prior to the diagnosis?	In your medical opinion, how long do you think the sickness existed prior to your diagnosis?

Did the patient have any symptoms prior to consulting you? ❑ Yes ❑ No
If Yes, please indicate the nature of the Symptoms and date Symptoms first started:

Are you the patient's usual physician? ❑ Yes ❑ No	When did patient first consult you for this condition?

Nature and Date of Treatment rendered

Has the patient ever had the same or similar condition/symptom? ❑ Yes ❑ No ❑ Not to my knowledge
If Yes, please indicate when and describe:

Doctors previously consulted by the patient for the above condition (Referring Doctor as well):

Name	Date	Name of Clinic / Hospital	Address

Has the patient ever suffered from any serious sickness (eg heart conditions, kidney failure, stroke, cancer etc) prior to this admission? ❑ Yes ❑ No
If Yes, please provide us with the diagnosis, first date of diagnosis and name and address of Doctor seen:

Describe the surgical procedures or treatment rendered. If no surgery was performed, please state treatment/medication given.

Date surgical procedures or treatment rendered

If excision was performed, please indicate the size of the lesion/tumor (please attach a copy of Histology Report):

Were any diagnostic / lab test done? ❑ Yes ❑ No
If Yes, please provide a copy of the Report.

Name of Physician	Name of Surgeon	Name of Anaesthetist

What is the prognosis of this sickness?

*Please tick the appropriate sickness classification:

- ❑ Alimentary system, includes liver & billary tract
- ❑ Musculo-skeletal system & connective tissue disorder
- ❑ Haematological disorders/autoimmune disorders
- ❑ Diseases of skin and subcutaneous tissue
- ❑ Symptoms, signs and ill-defined conditions
- ❑ Diseases of genito-urinary system
- ❑ Disease of the nervous system
- ❑ Cancer/malignant tumour growth
- ❑ Respiratory system
- ❑ Cardiovascular system
- ❑ Ear, nose & throat system
- ❑ Psychological/Psychiatric
- ❑ Metabolic & endocrine disease
- ❑ Eye
- ❑ Female diseases/condition
- ❑ Infectious diseases
- ❑ Dental/bucco-mucusal

Signature of Physician/Surgeon

Name and Address of Clinic/Hospital

Name/Designation

Date