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

Medical 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 (Company / Individual)

Name of Insured (As in NRIC/Passport)+			GST Registration / NRIC Number*
Business / Home Address*			Effective Date of Registration+ (dd/mm/yyyy)
Contact Person+			
Contact Number (H)	(O)	(HP)	Email

Particulars of Employee (if applicable)

Name of Employee (As in NRIC/Passport)	Date of Birth (dd/mm/yyyy)	NRIC / Passport Number*
Date of Employment (dd/mm/yyyy)	Eligibility for Benefits (eg. Plan A, Standard/Platinum)	Occupation

Particulars of Claimant (other than employee)

Name of Claimant (As in NRIC/Passport)			NRIC/Passport/BC Number*
Gender ❑ Male ❑ Female	Relationship to Insured/Employee	Date of Birth (dd/mm/yyyy)	Occupation
Contact Number (H)	(O)	(HP)	Email

+ If applicable * Delete if not applicable

Details of Claim

SICKNESS

Nature of Sickness / Final Diagnosis

Date Symptoms First Started (dd/mm/yyyy)	Date First Treated (dd/mm/yyyy)

Attending Doctor's Name and Address

Has the sickness been treated previously? ❑ Yes ❑ No

If Yes, please state Name and Address of the Physician for previous treatment:

Date of previous treatment:

Is the sickness due to pregnancy, abortion, miscarriage, sterilization or infertility? ❑ Yes ❑ No

If Yes, please specify condition:

Date of commencement:

Is this condition arising from employment? ❑ Yes ❑ No

INJURY

Nature and Extent of injury sustained

Date of Accident (dd/mm/yyyy)	Time of Accident ❑ am ❑ pm	Place of Accident

Is this a job-related accident? ❑ Yes ❑ No

State fully what happened

Attending Doctor's Name and Address

Has the claimant previously suffered from an injury to the same part? ❑ Yes ❑ No
If Yes, please give details:

OTHER INSURANCE OR COMPENSATION

Is the Insured/Claimant presently also insured for medical insurance under another Insurance Company? ❑ Yes ❑ No
If Yes, please state Name of Insurance Company and Policy Number:

Is the Insured/Claimant claiming from another Insurance Company/other sources? ❑ Yes ❑ No
If Yes, please provide a copy of their settlement details.

Supporting Documents

1. Original final detailed hospital bills or receipts
2. Original final clinic bills or receipts
3. Copy of Discharge Summary
4. Copy of work permit, if applicable

Medical Authorization (This portion must be completed by the Claimant)

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 Claimant

Name of Claimant

Declaration

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

Details of Payee:

Hospital	S$
Employer	S$
Employee / Claimant (Please state Full Name:_____)	S$
CPF Medisave / Medishield	S$

Signature of Insured

Company's Stamp (if applicable)

Name

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/BC Number
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