Group Hospital & Surgical Claim Form
(Student Medical Insurance)

Instructions:

Please submit the following documents within 1 month from date of discharge from hospital:

For hospitalization in Government / Restructured Hospital

1. Duly completed and signed claim form (Page 2) and a copy of the student pass
2. All original final hospital bills, doctor's/specialist's bills and receipts
3. Inpatient Discharge Summary
4. Inpatient Admission Report (if available)
5. Day Surgery Admission Report (if available)

For hospitalization in Private Hospital / Hospital outside Singapore

1. Duly completed and signed claim form (Page 2) and a copy of the student pass
2. All original final hospital bills, doctor's/specialist's bills and receipts
3. Medical Report from attending physician/ specialist (page 3)
4. Inpatient Admission Report (if available)
5. Day Surgery Admission Report (if available)

Please submit the completed documents to:

SINGAPORE POST CENTRE
P.O. BOX 15
SINGAPORE 914001
(Student Medical Insurance Claim)

For Claim information and Enquiries, please contact:

Ms Christina Chng
Hand phone : 97602569
Email : christina@enrichadvisory.com

Ms Genna Ang
Hand phone : 96715922
Email : genna@enrichadvisory.com

MEDICAL CLAIM FORM

This form is issued without admission of liability and it must be completed and returned to us immediately, whether or not a claim is made.

POLICYHOLDER INFORMATION

Name of Private Education Institution (PEI): **UNITEDWORLD INTERNATIONAL ACADEMY PTE LTD**	Policy No: **SD14M00715**

STUDENT DETAILS

Name (Mr/Miss/Mrs/Mdm):	NRIC/Passport No:	
	Date of Birth:	
	Telephone No:	
Address:	Email Address:	
Sex: M / F	Course Start Date:	Plan No:

State nature of illness & date upon which symptoms first occurred:

Did you seek medical treatment prior to being diagnosed with the illness for which you are now claiming? ☐ YES ☐ NO

If YES, state name & address of the physician:

Are you claiming from any other insurer in respect of this illness/injury? ☐ YES ☐ NO

If YES, state name of insurer & policy no:

TYPE OF ACCIDENT

How did the accident happen?	Road Related ☐ YES ☐ NO Work Related ☐ YES ☐ NO
Describe the nature of injuries sustained:	Others ☐ YES ☐ NO
Date & Time of Accident:	Place of Accident:

BANK ACCOUNT INFORMATION (for *GIRO Claims Processing*)

Name of Bank:	Bank Code:	Branch Code:
Bank Account No:	Name of Account Holder:	

I declare that I have complied with the conditions and warranties (if any) of the Policy and in no manner deliberately caused the said loss or damage or exaggerated the claim or sought unjustly to benefit by any fraud or willful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty Insurance reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.

I authorize the release of any medical information necessary to process this claim.

Student's Signature	***PEI Administrator's Name / Signature & PEI's Stamp***
Date	***Date***

MEDICAL INFORMATION (*to be completed by attending physician*)

Name of Patient:	NRIC/Passport No:
Date when the patient first consulted you:	Prior to the first consultation with you, when did patient first suffer the symptoms of the condition:
Presenting complaints:	
Duration of illness/injuries at time of consultation:	
Physical signs of injuries and/or other evident consistent with the injuries:	
Was the patient referred by another physician? ☐ YES ☐ NO If YES, state name, address & telephone number:	State your diagnosis of the illness/injuries:

INVESTIGATIONS DONE

Blood Test ☐ YES ☐ NO X Ray ☐ YES ☐ NO Others (Please specify)

If YES, please furnish copies of the reports/investigation results.

Type of surgical operation(s) done:

Date of Admission:	Date of Discharge:

Is there any connection between the present condition and any other pre-existing illness or previous accident? ☐ YES ☐ NO

If YES, please give details:

Is the condition of the patient:

Congenital in nature	☐ YES ☐ NO	Sexually transmitted disease	☐ YES ☐ NO
Genetic or chromosomal disorder	☐ YES ☐ NO	Related to cosmetic treatment	☐ YES ☐ NO
Mental/psychiatric disorder	☐ YES ☐ NO	Infertility related	☐ YES ☐ NO
Drug addiction/alcoholism	☐ YES ☐ NO	Treatment of teeth/gum tissue/oral cavity	☐ YES ☐ NO
Self-inflicted injury	☐ YES ☐ NO	Pregnancy related	☐ YES ☐ NO

If any of the above is YES, please give details:

Will illness/injury require further follow-up treatment? ☐ YES ☐ NO

If YES, please give details:

Any other relevant information:

I hereby certify that I have personally examined and treated the patient for the above illness/injuries and that the facts as given above present my opinion of the patient's condition.

Signature of Physician ***Date***

Name of Physician ***Telephone Number***

Company Stamp