GROUP MEDICAL INSURANCE CLAIM FORM

PART 1 : TO BE COMPLETED BY POLICYHOLDER & INSURED MEMBER - Please tick ☑ the type of claim and use 1 claim form per member

☐ Outpatient GP Claim ☐ Outpatient SP / XRLB Claims ☐ Dental Claim ☐ Pre-Hospitalisation Claim ☐ Inpatient Claim ☐ Post-Hospitalisation Claim

A. EMPLOYEE & / OR DEPENDANT

Policyholder (Employer) NINTEX		Policy Number 125386	
Insured Member (Employee) GAN KOK KOON		NRIC / Passport	Date of Birth
Occupation	Date of Employment	Plan No.	Sex F ☐ M ☐
Email Address	Contact Number Office:	HP:	
Claimant (Dependant)	Relationship Spouse ☐ Child ☐	NRIC No / Passport	Date of Birth / Sex F ☐ M ☐
Is the dependant employed? Yes ☐ No ☐ If yes, please furnish the name of employer:	Name and address of regular / family doctor		

B. DETAILS OF ILLNESS / ACCIDENT

1) Nature of Illness / Final Diagnosis		Symptoms experienced	
Date symptoms first started		Date First Treated	
2) Accident : Date & Time		Describe How Accident Happened & Nature of Injury	
Date of Admission	Date of Discharge	Name of Hospital / Clinic	Name and address of attending physician
Was the Accident work-related? Yes ☐ No ☐		Are you entitled to claim against Work Injury Compensation? Yes ☐ No ☐	

C. CLAIMS PAYMENT DETAILS – PLEASE NOTE THAT PAYMENT MODE WILL BE AS PER AGREED BY YOUR EMPLOYER WITH XXX LIFE

Claim cheque to be made payable to: (Please tick ☑ one only) Employer ☐ Employee ☐

	Bank Name		Branch Code				Bank A/c No.												

D. DECLARATION AND AUTHORISATION

(This part must be signed by the patient or patient's parent / legal guardian if the patient is below 21 years of age)

I / We hereby authorise XXX Life Insurance Singapore Private Limited ("XXX Life") to request from any physician, hospital, dentist, person or organization (including the Policyholder (the "Employer"), all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment and copies of all hospital and medical records concerning me / us and/or my dependants (where applicable) at any time and authorise the prior mentioned organizations to disclose all such information to XXX Life. A photocopy of this authorization shall be considered as effective and valid as the original.

I / We declare that the statements and answers stated are true and complete to the best of my / our knowledge and belief.

In connection with my / our claim, I / we give consent for XXX Life and XXX Insurance Singapore (collectively "XXX") and their respective representatives or agents to collect, use, store, transfer and/ or disclose the information (including that provided by sources other than myself) concerning me / us and/or my dependants, to or with all such persons (including any member of the XXX Group or any third party service provider, and whether within or outside of Singapore and the Employer when claiming under a Group Policy) for the purpose of enabling XXX to provide me / us and/or my dependants (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/ or managing my / our claims or the Employer's Group Policy(ies) with XXX (as the case may be), and for the purposes set out in XXX's Data Use Statement which can be found at http://www.xxx.com.sg ("Purposes").

Signature of Employee	Signature of Patient (if patient is dependant)	Date (DD/MM/YY)

E. TO BE COMPLETED BY EMPLOYER

Signature of Employer	Company's Name and Stamp	Date (DD/MM/YY)