TOKIO MARINE
INSURANCE GROUP

GROUP MEDICAL CLAIM FORM

Dear insured employee / spouse or child ("life insured"),

We refer to your claim for medical reimbursement.

In order for us to process your claim, we require the following:

For Outpatient Claim

(1) Group Medical Claim Form (to be completed by insured employee)
(2) Original medical invoices / receipts / bills
(3) Referral Letter from General Practitioner (GP) to Specialist / Hospital, if you have consulted a specialist and are entitled to reimbursement for specialist consultation

Claim will be payable to employee, unless otherwise advised.

For those accounts on "GIRO" payment mode, the claims will be credited into the employee's bank account. Please note that "GIRO" payment is only limited to outpatient claims.

For Inpatient Claim

(1) Group Medical Claim Form (to be completed by both employer and life insured)
(2) Group Medical Claim Report Form (refer to Note below)
(3) Original final hospital bills
(4) Detailed hospital bills are required for admission to private hospitals
(5) Consent for Medical Report

Please complete **all** questions in the form for prompt settlement of the claim.

Once we have received **all** the above required documents, we will process your claim and inform you of the outcome as soon as possible.

All the required documents must be forwarded to our company within **30 days** from the date of discharge from the hospital.

Upon approval of the claim, the claim cheque will be made in favour of the employer / company unless otherwise instructed by the employer / company under Page 1 of the claim form.

Note:

- If you are admitted to government / restructured hospitals, please submit **inpatient admission report** (for day surgery) or **inpatient discharge summary**, which is issued to patients by the hospitals upon discharge, for our company's consideration to waive the medical report. If these reports are not available, the Group Medical Claim Report Form is to be completed by your attending doctor and submitted to us.

- For admission to private or overseas hospitals / clinics, the Group Medical Claim Report Form is to be completed by your attending doctor and submit to us. Medical report fee is to be borne by life insured.

- All documents which are in foreign language must be officially translated to English before submitting to us.

GROUP MEDICAL CLAIM FORM

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Type of Claim – Please Tick: ☐ Outpatient ☐ Inpatient

Employee's Details - To Be Completed by Employee

Policy No.:	Name of Company:			
Name:		NRIC No.:	Employment Date:	
Gender: ☐ Male ☐ Female	Date of Birth:	Marital Status:	Occupation:	Contact No. / Email:

Outpatient Claim Details - To Be Completed by Employee

Name of claimant	NRIC / Passport no.	Nature of illness / diagnosis	Accident-related? If yes, to provide details of accident.	Date of visit (dd/mm/yy)	Amount incurred

If you have consulted a specialist and are entitled for the specialist benefit, please answer the following questions:

(i)	Is this claim related to the claimant's first visit to a specialist for the illness / diagnosis indicated above? ☐ Yes ☐ No **(If yes, please attach a copy of the referral letter)**	(ii)	Is this claim a follow-up from your previous hospitalization and/or surgery? ☐ Yes ☐ No If yes, please state date of hospitalization / surgery: _____

Inpatient Claim Details - To Be Completed by Employee

Name of Patient (if different from Employee):		NRIC:	Date of Birth:
Gender: ☐ Male ☐ Female	Marital Status:	Relationship to Employee: ☐ Spouse ☐ Child	Occupation:
☐ Illness (Please Tick if applicable)		☐ Accident (Please Tick if applicable)	
Nature of Illness:		Accident Date & Time:	
		Brief Description of Accident:	

Were you / your dependant hospitalised as a result of an illness or accident? ☐ Yes ☐ No If yes, please provide the Date of Admission & Date of Discharge:	Date of Admission:	Date of Discharge:

Nature of Operation **(Applicable if there is surgery performed)**:

Are you you claiming or intend to claim from the shield plan or any other insurance company(ies) or sources in respect of this illness / accident? ☐ Yes ☐ No

If yes, please provide details, including name of the insurance company, type of plan, whether claim has been notified and claim amount payable:

CONSENT & AUTHORISATION

Personal Data Notice

I agree and consent that the Company may collect, use, process and disclose the personal data in accordance with the terms and conditions as stated in the insurance application form and/or the Company's Data Protection Policy available at www.tokiomarine.com, which I have read, understood and agreed to the same.

Declaration

I declare that all answers given by me in this form is in every respect true and correct and that no material information has been withheld nor any relevant circumstances omitted. I hereby authorize:

(a) any medical source, insurance office, or organization to release to or when requested to do so by the Company, any relevant information concerning the abovenamed employee, and; (b) the Company to release to any medical source, insurance office, or organization, any relevant information concerning the abovenamed employee, at any time. A photocopy of this authorization shall have the same effect as the original.

Signature of Employee	Signature of Patient (For Dependant)	Date
_____	_____	_____

To Be Completed by Employer (APPLICABLE FOR INPATIENT CLAIM ONLY)

Effective Date of Coverage:	Date of Employment:	Plan:

Kindly state to whom the claims cheque should be made payable to: ☐ Employer / Company ☐ Employee

Personal Data Notice

We represent, warrant and undertake that collective consents have been obtained from each of our employees and their respective life assureds and/or dependents, to allow Tokio Marine Life Insurance Singapore Ltd. and Tokio Marine Insurance Singapore Ltd ("Tokio Marine Insurance Group") to collect, use, process and disclose the personal data in accordance with the terms and conditions as stated in the insurance application form or Tokio Marine Insurance Group's Data Protection Policy available at www.tokiomarine.com, which we / they have read, understood and agreed to the same.

Company Name & Stamp:	Signature of Employer:	Date of Signature:

Tokio Marine Life Insurance Singapore Ltd. (Company Reg. No.: 194800055D)
20 McCallum Street, #07-01 Tokio Marine Centre, Singapore 069046 T: (65) 6592 6100 F: (65) 6223 9120 W: tokiomarine.com

TOKIO MARINE
INSURANCE GROUP

GROUP MEDICAL CLAIM REPORT

1 Name of patient : _____ NRIC/Passport no : _____
(as stated in NRIC / Passport)

2 DETAILS OF CONSULTATION / TREATMENT

(a) Diagnosis : _____ ICD code : _____

(b) Date of diagnosis : _____ Surgical code (if any) : _____
(dd/mm/yyyy)

(c) Date of first consultation : _____ Date patient was first informed of diagnosis: _____
(dd/mm/yyyy) (dd/mm/yyyy)

(d) Please describe the symptoms presented during first consultation and exact date or duration of each symptom when it first appeared :

_____

(e) Based on clinical finding and pathology of the condition, how long do you think the illness / condition has existed prior to the first consultation with you?

_____

(f) Please provide full details of all treatment provided and the response.

_____

(g) Was the treatment related to the following conditions?

(i) Congenital conditions / physical defect at birth? ☐ Yes ☐ No

(ii) Nervous mental disorder / related to state of mind? ☐ Yes ☐ No

(iii) Treatment of teeth / gum tissue / oral mucosal? ☐ Yes ☐ No

(iv) Job-related injuries? ☐ Yes ☐ No

(v) Sexually transmitted disease, AIDS and all illnesses or diseases related to HIV? ☐ Yes ☐ No

(vi) Complications arising from pregnancy, childbirth, abortion, impotency, sterilization, birth control measures and or infertility ☐ Yes ☐ No

If **yes**, please specific the exact condition and the commencement date? Commence date:

_____ _____
(specific condition) (dd/mm/yyyy)

(vii) Alcoholism or drug abuse? ☐ Yes ☐ No

(viii) Cosmetic or plastic surgery? ☐ Yes ☐ No

(ix) Is the surgery medically necessary? ☐ Yes ☐ No

If any of the answers to Question 3g(i) – (ix) is "Yes", please provide full details:

_____

(h) (i) If surgery was performed, please specify the type and exact date of surgery :

_____

(ii) If there were more than 1 surgical procedure, were the surgical procedures approached through the same incision / orifice? If yes, please provide full details. ☐ Yes ☐ No

_____

(i) Please state the period of hospitalisation : _____

(j) Please specify the tentative date of further surgery if patient was scheduled : _____
(dd/mm/yyyy)

_____ _____
Hospital / Clinic Stamp Signature of Attending Doctor

Date (dd//mm/yyyy) _____ Name and Address

Qualification

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3 DETAILS OF ACCIDENT

If the condition was a result of an accident, please provide the following details.

(a) Date of accident : _____ (dd/mm/yyyy) Time of accident : _____

Place of accident : _____

(b) Describe in details how the accident happened :

_____

(c) Please describe in details the nature and extent of injuries / disabilities :

_____

(d) Were the injuries / disabilities the result of the accident described above? ☐ Yes ☐ No

(e) Was the patient under the influence of alcohol or drugs at the time of accident? ☐ Yes ☐ No

(f) Please provide full details if the cause of patient's condition/injury was a result of self-destruction or intentional self-infliction :

_____

4 MEDICAL HISTORY

(a) Has the patient previously suffered from the same illness? If yes, please provide the following : ☐ Yes ☐ No

(i) Date when the illness is first diagnosed : _____ (dd/mm/yyyy)

(ii) Name and address of the doctor who first treated the patient :

_____

(iii) Name(s) and address(es) of the attending doctor(s) :

_____

(iv) If the patient has been admitted to a hospital or treated for the same or different cause, please provide us with the name of doctor, hospital, the confirmed diagnosis and date of hospitalization :

_____

_____

(b) Are you the patient's regular doctor? ☐ Yes ☐ No If yes, since when (dd/mm/yyyy): _____

If **no**, kindly provide the Name and Address of his / her regular doctor, if known to you :

_____

(c) Was the patient being referred to you? ☐ Yes ☐ No

(i) If **yes**, please provide date of referral (dd/mm/yyyy) : _____

(ii) Name and address of the referral doctor :

_____

(d) If the patient is suffering from other significant illness(s)/condition(s), kindly provide details of illness / condition, date of first consultation and name of doctor/hospital :

_____

5 Kindly provide us with additional information, if any, to further assist us in assessing this claim:

_____

_____ _____

Hospital / Clinic Stamp Signature of Attending Doctor

Date (dd//mm/yyyy) _____ Name and Address / Qualification

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CONSENT FORM FOR MEDICAL REPORT

NAME OF PATIENT : _____

NRIC NO. : _____ POLICY NO. : _____

This consent form is required for an insurance claim.

Authorisation

I hereby authorize:

(a) any medical source, insurance office, or organization to release to or when requested to do so by Tokio Marine Life Insurance Singapore Ltd. and Tokio Marine Insurance Singapore Ltd. ("Tokio Marine Insurance Group"), any relevant information concerning the above-named patient, and;

(b) the Tokio Marine Insurance Group to release to any medical source, insurance office, or organization, any relevant information concerning the above-named patient, at any time.

A photocopy of this authorization shall have the same effect as the original.

Yours faithfully

_____

Signature of *Patient / Patient's Parent / Next-Of-Kin

Name : _____

Address : _____

_____

NRIC No. : _____ Relationship to patient : _____

* Delete accordingly

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