QBE Insurance (International) Limited
A member of the worldwide QBE Insurance Group Unique Entity No. S16FC0047K
60 Anson Road #11-01 Mapletree Anson Singapore 079914
Tel: 65-6224 6633 Fax: 65-6533 3270 www.qbe.com.sg

OUTPATIENT (Notification of Claim)

NOTE: Please complete all Sections and return this form to the Company together with original copies of detailed and itemised bills.

1. PARTICULARS OF CLAIMANT

Policy No:		
If group insurance, name of policyholder (employer):	Name of Claimant:	
NRIC/Birth Cert/Passport no:	Date of Birth:	Sex:
Name of insured (if claimant is a spouse/child):	Telephone no:	

2. STATEMENT OF CLAIMANT (By Parent if Claimant is a minor)

If as a result of an accident, please state injury:

Date: Time: Place:

Circumstances of accident:

Was the accident reported to the police? ☐ Yes ☐ No

If "Yes", which police station? (Report number if obtainable)

Whom do you consider was responsible for the accident? ☐ Self ☐ The other party

If other party, please specify name:

3. OTHER INFORMATION

Are you covered for the whole or any part of the medical expense resulting from the above-mentioned illness or accident by:

Work Injury Compensation Insurance? ☐ Yes ☐ No

Any other medical benefits schemes/personal accident, life or other form of insurance? ☐ Yes ☐ No

If the answer to any of the above question is "Yes", please state in full particulars:

Name and address of insurance company: _____

Policy no: _____ Expiry date of policy: _____

Other information: _____

4. DECLARATION AND AUTHORISATION TO RELEASE INFORMATION

I, the undersigned, hereby declare that the particulars stated on this form are true in every respect and authorise any physician or other person who has attended to me to release any information acquired in the course of my examination or treatment to QBE Insurance (International) Limited.

_____

Signature of Claimant (Parent, if a minor)

Date:

5. TO BE COMPLETED BY ATTENDING PHYSICIAN

A. Name of patient:

B(i). Diagnosis of condition(s):

(ii). Was the condition related to employment? ☐ Yes ☐ No
If "Yes", please give details:

(iii). Was the condition due to pregnancy, infertility or childbirth? ☐ Yes ☐ No
If "Yes", please state date of commencement of pregnancy:

(iv). Was the condition a congenital anomaly; a physical defect at birth; a genetic condition? ☐ Yes ☐ No
If "Yes", please specify:

(v). Was the condition a nervous or mental disorder? ☐ Yes ☐ No
If "Yes", please specify:

C(i). When did the patient first consult you for this condition?

Date:

(ii). Did patient have any symptoms related to this condition prior to consulting you? ☐ Yes ☐ No

(iii). How long had the patient been troubled by symptoms prior to consulting you?

(iv). Has patient ever had the same or similiar condition or symptoms related thereto? ☐ Yes ☐ No
If "Yes", please state when and describe:

(v). How long has the above sickness or injury existed?

(vi). Doctors previously consulted by patient for the above condition?

Name: Name of Clinic:

Approximate Date: Telephone:

Address:

D. Is the patient still under your care for this condition? ☐ Yes ☐ No
If "No", please give date service terminated:

E. What is the prognosis of this illness?

F.

Date	Service (state whether consultation or name of other service)	Amount charged for medicine or supplies only	Total charges

Name & Signature of Physician

Date:

Address & Official Stamp