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

INSTRUCTIONS ON HOSPITAL & SURGICAL CLAIM PROCEDURE

The Insured shall within 31 days of an event giving rise to a claim under the policy, give written notice to QBE stating full particulars of the claim.

You will need to complete and submit the following documents :

a) All original fully paid and confirmed finalised tax invoices and receipts. For private hospital treatment, please submit both the summary and itemised hospital tax invoices and the private specialist's invoice for professional fee including medicine and service rendered.

b) A copy of all investigation results/reports, examples: Histology, Gastroscopy, Colonoscopy, Cardiac report, etc., and any doctors referral memo or letter. For day surgery at any Singapore Government/Restructured Hospitals, please enclose a copy of the Day Surgery Summary, or patient's signed consent to proceed with the surgery or procedure.

c) A copy of death certificate, police report, diagnostic results, if applicable.

d) A copy of valid student pass for dependants above the age of 19 years.

e) The following sections of the Claim Form need to be completed :

- **GOVERNMENT / RESTRUCTURED HOSPITALS**
  For any hospitalisation at Government / Restructured Hospitals in Singapore, Section 1 to 7 of the Hospital and Surgical Claim Form to be completed by dependant / staff, and attached with the Inpatient Discharge Summary.

- **PRIVATE HOSPITALS / CLINICS / OVERSEAS HOSPITALS**
  For any hospitalisation at Private Hospitals / Clinics or Overseas Hospitals, Section 1 to 7 of the Hospital and Surgical Claim Form to be completed by dependant / staff and Section 8 to be completed by the attending Physician / Surgeon.

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HOSPITAL AND SURGICAL CLAIM FORM

- Please ensure that all information are fully accurately completed so as to expedite claim processing.
- ORIGINAL FINAL SUMMARY AND ITEMISED tax invoices and receipts must be attached and submitted within one month from the date of discharge.

1. DETAILS OF EMPLOYER / POLICYHOLDER

Name of employer (if group policy)

Name of policyholder (for Individual/Exe/TotalCare Plan only)

For SIA group of employees, please state name, staff no. and NRIC/Passport no. in this space

Mailing address :

2. POLICY NO. :

3. DETAILS OF PATIENT

Name of patient :

Is the patient : Self / Spouse / Child *(* Delete where appropriate)*

NRIC/Passport/Birth Cert No. :

Sex : Male / Female *

Marital Status :

Date Of Birth :

Email :

Home no. :

Mobile/hp no. :

Office no. :

4. OTHER POLICY:

If you are insured under any insurance policy which might indemnify you for this loss, please state name of insurer and policy no. :

5. DESCRIPTION OF ILLNESS / ACCIDENT

(To be completed by the patient or parent of minor)

Date symptom(s) first began / date of accident :

Date symptom(s) / injury first treated :

Symptom(s) of illness / how & where did the accident happen :

Name of doctor &/or clinic consulted when symptom(s) / injury first began/sustained :

Doctor's diagnosis :

Name of doctor &/or clinic who referred you to the specialist now treating you. Please attach referral memo where available.

Date admitted & discharged :

Date of surgery:

6. OTHER INFORMATION

(To be completed by employer for group policy. Not applicable to SIA group of companies)

Note: 6A to 6C are mandatory fields which need to be completed. For headcount cover, please enclose a copy of the employee's Work Permit or S-Pass.

6A. Was an I-Report lodged with the MOM? ☐ Yes ☐ No If "Yes", please attach a copy of the I-Report when filing claim.

6B. The name of the insurer & policy number insuring your company employee

i. Work Injury Compensation insurance policy no. & name of insurer :

ii. Group Personal Accident insurance policy no. & name of insurer :

iii. Group Travel insurance policy no. & name of insurer :

6C. Name of employee claiming under this medical policy :

i. Date employee was employed & current occupation/job title :

ii. Room & Board entitlement/Plan Type :

6D. For group policy on Transferable Medical Insurance Scheme (TMIS), please state :

i. Name of employee's previous employer and their medical insurer : ______

ii. Last date of service in previous job : ______

iii. The certificate number contained in the Transferable Medical Insurance Certification (TMIC) :
(A TMIC, where a medical insurance includes TMIS. is issue to an employee upon his termination of employment)

7. DECLARATION AND AUTHORISATION TO RELEASE INFORMATION

I, the undersigned, hereby declare that the particulars stated on this form are true in every respect and that I have supplied full information on all particulars relevant to this claim. I authorise any physician or other person who has attended to me, or my spouse or dependant to release any information acquired in the course of examination or treatment to QBE Insurance (International) Limited. I also authorise the hospital Billing/Business/ Finance Office to release and provide any billing documents, invoices or other information relating to me, or my spouse or dependant directly to QBE Insurance (International) Limited in any form or mode of transmission when requested by them. A copy of this authorisation shall be considered as effective and valid as the original.

______
Signature of patient (Parent, if a minor)
Date:

______
Signature of employee & NRIC/Passport No., if the employee is not the patient
Date:

To be completed by employer for group policy. Not applicable to SIA group of companies

We, the employer, hereby declare that the date of employment, occupation and information stated in Section 6 - Other Information are true in every respect and the employee claiming on the policy is in our permanent full-time employment actively working on any scheduled work days, performing in the customary manner all the regular duties of his/her employment either at one of our business establishments or at location which our business requires him/her to be present at the time when the Policy was issued to us. We also declare and warrant that the employee claiming on the policy remains in our valid employment before and after the time of signing this declaration and shall inform QBE Insurance (International) Limited at once if he/she ceased to be a full-time employee with us.

______
Employer's signature and company stamp
Date :

8. PLEASE ARRANGE FOR THIS SECTION TO BE COMPLETED BY YOUR ATTENDING PHYSICIAN/SURGEON IF YOU WERE ADMITTED TO A PRIVATE HOSPITAL OR HOSPITAL OUTSIDE SINGAPORE

A. Name of patient :

B.(i). Final Diagnosis and ICD Code (Based on ICD, 1975, WHO) :

(ii). What is the cause of the illness/injury?

(iii). Patient's description of the symptom(s) and the duration experienced, or how the injury was sustained

(iv). Has the patient ever suffered from an episode of similar injury or symptom(s) (including similar symptom(s) of lesser severity, chronic or acute, or which wax and wane, or relapse and remit intermittently) ☐ Yes ☐ No

Has this diagnosis been made in the past? ☐ Yes ☐ No

(v). Date patient first developed symptom(s) or when injury was first sustained:

(vi). Date patient first sought medical treatment for the described symptom(s), or injury :

(vii). Name of the doctor, clinic or hospital consulted when symptom(s) first developed :

(viii). Name of other doctors, clinics or hospitals visited previously with reference to the symptoms or injury described in para iii, iv & vi

Name of doctor, clinics/hospitals	Exact date of visit, or year where the exact date is not avaliable

C. (i). Name of the doctor who referred the patient to you (Please attach a copy of the referral memo with this report)

(ii). Was the patient already on long term medication or required regular follow-up with a doctor for the illness/injury stated in para B.(i).? If "Yes", what long term medication is the patient using and what history of regular follow-up did the patient offer?

D. (i). The exact name of the surgical procedure(s) or treatment rendered. (Please attach such other reports as, histology/gastro-colono, cardiac report, etc., when returning this report)

Date of surgery or treatment rendered :

Operation table and code :

(ii). If no surgery was performed, please state treatment/medication given :

E. What is the prognosis of this condition?

F. Is this treatment related to

(i). past or recent pregnancy or childbirth? ☐ Yes ☐ No

(ii). abortion or miscarriage? ☐ Yes ☐ No
If related to miscarriage, was it due to accident?

(iii). infertility/subfertility condition? ☐ Yes ☐ No

(iv). correcting infertility/subfertility condition? ☐ Yes ☐ No

G. Is this condition

(i). a congenital anomaly; a physical defect at birth; a genetic condition? ☐ Yes ☐ No
If yes, when according to the patient or parent (s), they knew about it?

(ii). a mental or nervous disorder? ☐ Yes ☐ No

(iii). a refractive error of the eye? ☐ Yes ☐ No

(iv). due to intentional self inflicted injury or drug overdose; excessive consumption of alcohol; use of narcotics or similar drugs or agents? Please circle one, if "Yes" ☐ Yes ☐ No

(v). due to sexually transmitted disease? ☐ Yes ☐ No

H. Is this a cosmetic surgery? If "No" please explain why is the surgery necessary : ☐ Yes ☐ No

I. Is this a dental surgery/treatment? ☐ Yes ☐ No

J. Is this a job related injury? ☐ Yes ☐ No

Signature of Physician/Surgeon and Official Stamp

Name/Designation :

Name and Address of Clinic/Hospital

Date :