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Group Hospital and Surgical Claim Form

Policy No. ______________________________ Plan No. ______________ Intermediary ________________________

Section 1 – Particular of Policy Holder and Insured Member

Name of Policyholder (Employer) ____

Insured Member (Employee) ____

Date of Employment ______________________ NRIC/Passport No. ______________________

Address ____

Email Address ____

Telephone No. (Office) ______________________ (Home) ______________________

Date of Birth ______________________ ☐ Male ☐ Female

Particular of Employee's Dependent *(To be completed if the claimant is the dependent of the employee.)*

Full Name of the Dependent ____

NRIC, FIN, Passport or BC Number ______________________ Date of Birth ______________________

☐ Male ☐ Female Relationship to Employee ______________________

Section 2 – Details of Sickness or Accident

Sickness

a. Nature of the illness ____

b. Describe symptoms ____

c. Date symptoms first started ____

d. Name of the hospital ____

e. Date of hospitalisation or day surgery, from ______________ to ______________

f. Name and address of regular General Practitioner or Clinic ______________________

____

Accident *(Please complete the following if you have sustained injury as a result of an accident.)*

a. Date and time of the accident ____

b. Place of the accident ____

c. Accident details ____

____

		Yes	No
d.	Was the accident work-related?	☐	☐
e.	Are you entitled to claim against the Work Injury Compensation?	☐	☐
f.	Are you claiming from any insurer or any other parties on the medical bills?	☐	☐

If yes, please submit a copy of the settlement letter from the other party.

Section 3 – Personal Data Collection Statement

1. In order to process, evaluate, administer and/or manage your application, relationship, account and/or policy with Great American Insurance Company – Singapore Branch ("**Great American**"), Great American will necessarily need to collect, use, disclose and/or process your personal data or personal information about you. Such personal data includes (i) information set out in this statement and any other personal information provided by you or already in the possession of Great American as previously provided by you; and (ii) your claims.
2. Such personal data will be collected, used, disclosed and/or processed by "Great American" for the purpose(s) of:
   a. considering whether to provide you with the insurance you applied for including considering whether to accept any renewal request;
   b. processing your application for underwriting and insurance;
   c. administering and/or managing your relationship, account and/or policy with Great American;
   d. processing and/or dealing with any claims including the settlement of claims and any necessary investigations relating to the claims, under your policy;
   e. carrying out due diligence or other screening activities (including background checks) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by Great American;
   f. carrying out your instructions or responding to any enquiries by you;
   g. dealing in any matters relating to the services and/or products which you are entitled to under a policy which you are applying for or have applied for (including the mailings of correspondence, statements, invoices, reports or notices to you, which could involve disclosure of certain personal data about you to bring about delivery of the same, as well as on the external cover of envelopes/mail packages);
   h. investigating fraud, misconduct, any unlawful action or omission, whether relating to your application, your renewal request, your claims or any other matter relating to your policy, and whether or not there is any suspicion of the aforementioned; and/or
   i. complying with applicable law in administering and managing your relationship with Great American.
3. We may/will also be collecting from sources other than yourself, personal data about you, for one or more of the above Purposes, and thereafter using, disclosing and/or processing such personal data for one or more of the above Purposes.
4. Your personal data may/will be disclosed by Great American to affiliates of Great American and third parties such as third party service providers, reinsurers or agents (including its lawyers/law firms) ("**Relevant Parties**"), which may be sited outside of Singapore, for one or more of the above Purposes, and such Relevant Parties would be processing your personal data for Great American in relation to one or more of the above Purposes.
5. By signing below, you
   a. consent to Great American collecting, using, disclosing and/or processing your personal data for the Purposes as described above;
   b. consent to Great American collecting personal data about you from sources other than yourself and using, disclosing and/or processing the same, for one or more of the Purposes as described above;
   c. consent to Great American disclosing your personal data to the Relevant Parties, for the Purposes as described above; and
   d. consent to Great American transferring your personal data out of Singapore to the Relevant Parties, for the Purposes as described above.

Section 4 – Authorisation and Declaration

I confirm that I understand and agree to the 'Personal Data Collection Statement'.

I hereby authorise any hospital, medical practitioner, clinic, insurance office or any person(s) or organisation(s) who has/have attended to me for any reason, to disclose to **GREAT AMERICAN INSURANCE COMPANY – SINGAPORE BRANCH** all information in respect of any illness or injury of which I have sustained and to provide copies of all hospital or discharge summaries, medical records/certifications, including previous medical history. The information given herein is true and correct in accordance to the best of my knowledge.

____

Signature of Employee

____

Signature of Patient
(To be signed by patient's parent or legal guardian if the patient is below 21 years old)

____

Date

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To be completed by policyholder *(Company/Employer)*

Name of the Company (Employer) ____

____

Name of Authorised Personnel

____ ____

Signature and Company's stamp **Date**

NOTE
1. *The acceptance of this claim form is not to be construed as an admission of policy's liability.*
2. *All original final bills, certificates and supporting documents must be provided to substantiate your claim.*
3. *Great American Insurance Company – Singapore Branch hereby reserves all rights under the policy terms and conditions.*

Please submit the following documents within 30 days of the patient's discharge from hospital:
1. To complete Section 1 to 4 of the claim form.
2. Original final hospital bills as well as pre- and post-medical bills.
3. For admission into a government/restricted hospital, please provide the Inpatient discharge summary report or day surgery discharge summary report/ambulatory form / hospital pre-admission form.
4. For admission into a private / overseas hospital, please provide the original itemized hospital bill together with Section 5 of the claim form completed by the attending doctor. Please note that medical report fee is not admissible.
5. A copy of all the diagnostic investigation report pertaining to the medical condition for this admission.
6. A copy of the relevant incidence or police report pertaining to an accident related claim.

Section 5 – Attending Physician's Statement *(To be completed by the attending doctor.)*

Yes No

Applicable for hospitalisation or day surgery at private/overseas hospital or clinic

1. Name of the Patient ______
2. Final Diagnosis and ICD Code *(Based on ICD 1975 Revision, WHO)* ______
3. What is the underlying cause(s) of the diagnosed condition? ______
4. Name the doctor/hospital/clinic who referred the patient to you. Please attach a copy of the referral memo with this report. ______
5. What were the complaints or symptoms presented during the first consultation? ______
6. When was the first onset of the medical condition/symptoms? ______
7. Has the patient ever had the same or similar condition/symptoms? ☐ Yes ☐ No

   If yes, please indicate the medical condition sought, name and address of the attending doctor and date of visit. ______
8. Was the patient already on long-term medication or regular follow-up with a doctor for the illness/injury? ☐ Yes ☐ No

   If yes, please advise the name of the medication and the history of the regular follow-up of the patient. ______
9. Date and type of operation or treatment performed. ______

   For surgery, please advise the surgical operation table and code. ______

   If no surgery was performed, please state the treatment and medication given. ______
10. Where two or more surgical procedures were performed, please specify whether they were done through the same incision. ______
11. Was the treatment medically necessary? ☐ Yes ☐ No

    If no, please advise in details on the reason.
12. Was the condition or treatment related directly or indirectly to:

    a. Past or recent pregnancy or childbirth? ☐ Yes ☐ No
    b. Abortion or miscarriage? ☐ Yes ☐ No
    c. Infertility/subfertility condition? ☐ Yes ☐ No
    d. Congenital abnormalities; a physical defect at birth; hereditary conditions or disorder? ☐ Yes ☐ No

       If yes, when was it first made known to the patient or the parents of the patient? ______
    e. Development and/or learning disorders? ☐ Yes ☐ No

       If yes, please advise further. ______
    f. A psychological, mental or nervous disorder? ☐ Yes ☐ No
    g. Due to intentional self-inflicted or drug overdose; excessive consumption of alcohol; use of narcotics or similar drug/agents, or gambling addiction? ☐ Yes ☐ No

       If yes, please advise which one. ______

Section 5 – Attending Physician's Statement *Continued*

		Yes	No
h.	A sexually transmitted disease?	☐	☐
i.	A cosmetic surgery?	☐	☐
	If no, please explain the reason the surgery is necessary. ______________________		
	____		
j.	A dental surgery/treatment?	☐	☐
k.	A job/work-related injury/disease?	☐	☐

____
Signature of Physician/Surgeon and Official Stamp

____
Name and Address of Clinic/Hospital

______________________________ ______________________________
Name/Designation **Date**

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