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 GROUP 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 bills and receipts

b) A Physician's summary of cost of treatment including medicine and service rendered

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 5 of the In-Patient 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 5 of the In-Patient Claim Form to be completed by dependant / staff and Section 6 to be completed by the attending Physician / Surgeon

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INPATIENT (Notification of Claim)

- Please ensure that all information are fully accurately completed so as to expedite claim processing.
- All relevant ORIGINAL FINAL ITEMISED medical bills and receipts must be attached & submitted within one month from the date of discharge.

1. DETAILS OF EMPLOYER / POLICYHOLDER

Name of Employer / Policyholder:	Policy No.:

2. DETAILS OF EMPLOYEE

Name of Employee / Staff No.:	NRIC/Passport No.:	Sex: MALE / FEMALE*
Present Address:	Date of Birth:	Marital Status:
	Patient is: Self / Spouse / Child*	Date of Employment:
If the patient is your dependant, please provide the following information below:		
Name of Patient (Dependant):	NRIC/Birth Cert/Passport No.:	Sex: MALE / FEMALE*
Date of Birth:		

(Delete where appropriate)*

3. DETAILS OF ILLNESS / ACCIDENT

Nature of sickness:	Date illness first began/ Date of accident:	Date illness/injury first treated:
Name of hospital confined:	Date admitted:	Date discharged:
Name & Address of attending physician/surgeon:	Date surgery performed : (if any)	
Describe how and when the accident/illness/disease took place:		

Please complete if hospitalisation was due to accident	
Was the accident reported to the police? If "Yes", please furnish a copy of the police report.	☐ Yes ☐ No
Whom do you consider responsible for the accident? If "The other party", please specify name and contact particulars:	☐ Self ☐ The other party
Are you eligible to claim for this treatment against any other insurance policies? If "Yes", please give details:	☐ Yes ☐ No

4. OTHER INFORMATION

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

Any other medical benefits schemes/personal accident, workmen's compensation, life or other forms of insurance (such as Transferable Medical Benefits) ☐ Yes ☐ No

If "Yes", please state insurance company: ____________________

Type of Policy: ____________ Policy No.: ____________ Expiry Date: ____________
(Please submit a copy of the insurance company's claim settlement letter/payment voucher)

5. 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 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:

____
Signature of witness
Name of witness:
Identity Card No.:

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

A. Name of patient:

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

(ii). Did you inform the patient of your diagnosis? ☐ Yes ☐ No
If "Yes", please indicate when:

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

(iv). Please specify the approximate date of discovery of the illness or injury:

(v). How long has the illness/injury been existing prior to consulting you?

(vi). Did the patient have any symptoms prior to consulting you?
If "Yes", please indicate the nature of symptoms and date symptoms first started:

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

C(i). Nature and Date of treatment rendered:

(ii). Has patient ever had the same or similar condition or symptom?
If "Yes", please indicate when and describe:

(iii). Doctors previously consulted by patient for the above condition?
Name: Name of Clinic:
Approximate Date: Address:

(iv). Describe the surgical procedures or treatment rendered. Please attach copies of available reports (eg. histology, gastroscopy, etc):
If no surgery was performed, please state treatment/medication given:
Date of surgical procedures or treatment rendered:
Operation code: Operation table:

(v). Is the patient still under your care for this condition? ☐ Yes ☐ No
If "No", please give date service was terminated, and furnish name and address of doctor if the patient has been referred to another doctor for follow-up:

(vi). What is the prognosis of this condition?

D. Is this treatment related to

(i). pregnancy or childbirth? ☐ Yes ☐ No
(ii). abortion or miscarriage? ☐ Yes ☐ No
If related to miscarriage, was it due to accident? ☐ Yes ☐ No
(iii). infertility/subfertility condition? ☐ Yes ☐ No
(iv). correcting infertility/subfertility condition? ☐ Yes ☐ No

E. Is this condition

(i). a known congenital anomaly; a physical defect at birth; a genetic condition? ☐ Yes ☐ No
(ii). a mental or nervous disorder? ☐ Yes ☐ No
(iii). a refractive error of the eye? ☐ Yes ☐ No
(iv). due to self inflicted injury? ☐ Yes ☐ No
(v). due to sexually transmitted disease? ☐ Yes ☐ No

F. Is this

(i). a cosmetic surgery? ☐ Yes ☐ No
If "No", please explain why surgery is necessay:
(ii). a dental surgery/treatment? ☐ Yes ☐ No

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

Signature of Physician/Surgeon and Official Stamp
Name/Designation:

Name and Address of Clinic/Hospital
Date: