MS FirstCapital

MS First Capital Insurance Limited (Co.Reg. No. 195000106C)
6 Raffles Quay #21-00 Singapore 048580
Tel: (65) 6222 2311 Fax: (65) 6222 3547

**Claims & Motor Underwriting Dept:** 36 Robinson Road #16-01 City House Singapore 068877
Tel: (65) 6507 3848 Fax: (65) 6507 3849
www.msfirstcapital.com.sg

# HOSPITAL & SURGICAL CLAIM FORM

| | | | |
|---|---|---|---|
| NOTE: ALL QUESTIONS UNDER SECTION 6 HAVE TO BE COMPLETED BY CLAIMANT'S ATTENDING PHYSICIAN/SURGEON | | | |
| 1. PARTICULARS OF POLICYHOLDER | | | |
| (A) | Policy No. | | |
| (B) | Name of Policyholder | (If group insurance, name of employer) | |
| (C) | Name of Insured | (Please indicate if claimant is a spouse or child) | |
| 2. PARTICULARS OF CLAIMANT | | | |
| (A) | Name | | |
| (B) | NRIC/Birth Certificate/Passport No. | | |
| (C) | Date of Birth | (dd/mm/yyyy) | |
| (D) | Gender | | |
| 3. STATEMENT BY CLAIMANT | | | |
| (A) | i. Nature of Sickness | | |
| | ii. Date sickness first began | | |
| | iii. Date first treated | | |
| | iv. Name of Hospital confined | | |
| | v. Date admitted | (dd/mm/yyyy) | |
| | vi. Date discharged | (dd/mm/yyyy) | |
| | vii. Name of attending Physician/Surgeon (*Please give name of clinic if applicable*) | | |
| | viii. Date surgery was performed (if any) | | |
| | ix. Total amount of claim (SGD) | | |
| (B) | i. If injury was as a result of an accident, please provide details as follows | | |

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| | | |
|---|---|---|
| | Date & Time of Accident : _____<br><br>Location where Accident happened : _____ | |
| | ii. Please describe circumstances of accident :- | |
| | iii. Was the accident reported to the police?<br><br>If " Yes" let us have a copy of the Police Report | [ ] Yes [ ] No |
| | iv. Whom do you consider was responsible for the accident? | [ ] Self [ ] The other party |
| | v. If other party, please specify name and contact details (if any) :- | |
| 4. | OTHER INFORMATION | |
| (A) | Are you covered for the whole or any part of the medical expenses resulting from the abovementioned illness or accident by:- | |
| | i. Work Injury Compensation Insurance | [ ] Yes [ ] No |
| | ii. Any other medical benefits schemes/personal accident, life or other forms of insurance | [ ] Yes [ ] No |
| (B) | If the answer to any of the above question is "Yes", please state full particulars:- | |
| | i. Name of Insurance Company | |
| | ii. Address of Insurance Company | |
| | iii. Policy No. | |
| | iv. Expiry Date of Policy | |
| | v. Other Information | |

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## 5. DECLARATION & AUTHORISATION TO RELEASE INFORMATION

I/ We declare that the above information is true and complete to the best of my/our knowledge and belief and I/we claim in respect thereof the protection of my/our policy. I / We hereby acknowledge, consent and agree that:

MS First Capital Insurance Limited (MSFC) may collect, use and disclose all personal data provided or as may be provided by me / us and through other sources as MSFC deem relevant for the purposes as contemplated in this form including but not limited to policy servicing, processing, investigating, handling, administering and/or settling my / our claim with MSFC or other insurers;

MSFC may disclose the personal data to the third parties (whether in or outside Singapore) in carrying out the above purposes;

The personal data protection clauses herein ("DPC") are not exhaustive. By signing this form, I / we declare that I / we have read, understood and agreed to be bound by the prevailing Personal Data Protection Act 2012 as supplement to the DPC. If any inconsistencies between the DPC and the Data Protection Act 2012, the latter shall prevail;

If I / we provide third parties' personal data (e.g. information of the life assureds, insured persons, beneficiaries, beneficial owners, dependents, spouse, children, parents, siblings, customers, prospects, payees and/or employees) to MSFC, I / we represent and warrant to MSFC that prior consents have been obtained from each of the third parties for the collection, usage, disclosure and processing of their personal data in the manner as set out above and the Data Protection Act 2012; and

I / We shall indemnify MSFC for all losses and damages which may be suffered by MSFC arising out of the breach of the declarations, representations and/or warranties herein.

I / We authorise any physician or other person who has attended to me (Claimant) to release any information acquired in the course of my examination or treatment to MSFC.

| | |
|---|---|
| Date | Witness's Name |
| Signature of Claimant (Parent, if Minor) | Witness's NRIC or Passport No. |
| Signature of Policyholder | Signature of Witness (Must be above 21 year old) |

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6. MEDICAL REPORT BY ATTENDING PHYSICIAN/SURGEON
   - This form is to be completed by the Claimant's Attending Physician/Surgeon.
   - The issue of this form is not an admission of liability by the Insurer.
   - The Claimant must obtain at his own expenses for this report from his Attending Physician/Surgeon.

| | | |
|---|---|---|
| 1. | Claimant's Name as per NRIC/Passport | |
| 2. | Diagnosis of Condition(s) | |
| 3. | What were the complaints or physical findings? | |
| 4. | Was the condition(s) related to employment? If "Yes", please provide details"- | [ ] Yes [ ] No |
| 5. | Was the conditions(s) due to pregnancy, infertility or childbirth? If "Yes", please provide date of pregnancy or first treatment for infertility:- | [ ] Yes [ ] No |
| 6. | Was the conditions(s) due to a congenital anomaly, under the influence of intoxicant(s), nervous or mental disorder? If "Yes", please provide details:- | [ ] Yes [ ] No |
| 7. | When did claimant first consult you for this condition(s)? | |
| 8. | How long had the claimant been troubled by symptoms prior to consulting you? | |
| 9. | Had the claimant ever had the same or similar condition(s) or symptom(s) relating thereto? If "Yes" kindly indicate the last onset of condition(s) or symptom(s) :- | [ ] Yes [ ] No |
| 10 | For how long has the above condition(s)/sickness/injury existed? | |
| 11. | Name and Nature of Surgical or Obstetrical Procedure (if any) | |
| 12. | Date of Procedure performed :- | Location where Procedure performed<br>[ ] Hospital [ ] Clinic [ ]Day Surgery Centre [ ] Others |

I hereby certify that the above-named met with the accident referred to and that the foregoing statements are correct.

| | |
|---|---|
| Name and MCR No. of Attending Physician/Surgeon | Address and Official Stamp of Hospital/Clinic |
| Signature of Attending Physician/Surgeon | Date |