

Complete Sections A and B, and sign the Declaration if:

- You are claiming only for out-patient doctor visits, medications, and general laboratory tests, and
- The doctor has written the diagnosis on the bill or receipt, or on a separate note, and
- You have not been advised you may require surgery, hospitalisation, or specialised testing for this disability.

Complete Sections A and B, and have your physician fill out Section C if:

- You are claiming for in-patient, emergency, or surgical claims, or claims involving complex treatments/tests, accidental injury, or major illness.



SECTION A

Policy/Member Information

Name of Patient: _____

 Policyholder name: _____

 Policy Number: _____
 Member Number: _____
 ID Number: _____
 Social Security No.: _____
 (If U.S. Citizen)

Contact Details (if different from policy)

Address: _____

 Country: _____
 Postal Code: _____
 Telephone (H): _____
 Telephone (O): _____
 Facsimile: _____
 Email: _____

Send settlement to this address

In what currency would you like your claim to be paid? US\$ S\$



SECTION B

To be answered by Member (or parent if a minor)

If this claim pertains to illness:

1. What is the doctor's diagnose?

2. When and how did this illness first occur?

3. When did you first consult a doctor about this problem or these symptoms?

4. Have you ever had a similar illness or symptoms? If yes, please give full details below (including dates, treatments received):

If this claim pertains to an Accident:

1. What is the nature of this injury?

2. Date, time, and exact place of accident:

3. Briefly describe how this accident occurred:

4. Was a third party involved? If yes, please describe his/her part in this accident, and state whether reimbursement or other compensation will be provided.

For Dental work:

Name/ type of procedure:

Declaration

I hereby declare that all information provided on this form and the documents submitted herewith is true and correct to the best of my knowledge and belief. The amounts claimed are the actual charges incurred by me, are legally due to me under the terms of this policy, and are not recoverable from any other source.

Authorisation for Release of Information

I authorise any doctor, hospital, or other health provider or facility, insuring or reinsuring company, or employer to release to the Insurer ("the Company") any information or records they may have regarding my health, tests or treatments I have received, benefits or compensation therefore. If this claim relates to an accident, past or present, I also authorise any governmental body, agency, or other person or organisation who may have records pertaining to such accident to release such records or information.

I understand that this information will be used by the Company to determine eligibility for benefits, and that any information obtained will not be released by the Company to any person except to reinsuring companies or other persons or organisation(s) performing business or legal services in connection with my claim, save as may be required by law. I agree that a photocopy or facsimile of this release shall be as effective as the original.

Any information collected or held by Us whether contained in the Application / Proposal or Claim Form or otherwise obtained in any other manner, may be used and disclosed to Our associated individuals / companies or any independent third parties (within or outside Singapore) for any matters related to your claim and to communicate with You for any purpose.

Signature of Member
(parent if minor)

Date

 **SECTION C**

To be answered by Attending Physician

1. State briefly nature of illness or injury:

2. When did the symptoms first arise?

3. What is the underlying cause of the condition being treated?

4. On what date did the patient first consult you for this condition?

5. Has the patient ever suffered from this condition before?

- No Yes (explain)

6. Has the patient ever had any similar condition or related symptoms before this incident?

- No Yes (explain)

7. Is this related to any accident or injury, or in any way connected with the patient's employment or job duties?

- No Yes (explain)

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