HSBC Insurance

# Group Hospital & Surgical Insurance Claim Form

**Instructions:**

Please furnish the following documents within one month from date of discharge from hospital:

**For hospitalisation in Government / Restructured Hospital:**

(1) Duly completed and signed claim form (Part 1)

(2) All original final hospital bills, doctor's bills and receipts

(3) Inpatient Discharge Summary

(4) Inpatient Admission Report (if available)

(5) Day Surgery Admission Form (if available)

Please note we will reimburse up to $75 for the medical report from Government / Restructured Hospital should we need the medical report to assess the claim.

**For hospitalisation in Private Hospitals / Clinics / Hospitals outside Singapore**

(1) Duly completed and signed claim form (Part 1)

(2) Medical Report by attending physician / surgeon (Part 2) – Medical report fee to be borne by claimant

(3) All original final summary hospital bills, all original final itemised hospital bills, doctor's bills and receipts

HSBC Insurance

# Group Hospital & Surgical Insurance Claim Form

HSBC Insurance (Singapore) Pte. Limited
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*Company registration no 195400150N*

**Part 1**

## A. Employee's and Claimant's Details

| | | | | |
|---|---|---|---|---|
| Policyholder (Employer) | | | Policy Number | |
| Insured Member (Employee) | | | NRIC / Passport No | Date of Birth |
| Occupation | | Date of Employment | Sex: M / F | Plan No. |
| Email Address | | Contact Number<br>(Office) (HP) | | |
| Claimant (Dependant) | Relationship<br>☐ Spouse<br>☐ Child | NRIC No / Passport No | Date of Birth | Sex: M / F |
| Is the dependant employed? ☐ Yes ☐ No<br>If yes, please furnish the name of employer | | Name and address of regular / family doctor | | |

## B. Claims Details

| | |
|---|---|
| Diagnosis | Symptoms experienced |
| Date symptoms first started | Date **FIRST** consulted doctor or took drugs |

| | | |
|---|---|---|
| Name & address of doctor **FIRST** visited for this condition | Was the illness due to employment?<br>☐ Yes ☐ No | Were you pregnant at the time of hospitalisation? (for female claimant)<br>☐ Yes ☐ No |

| | |
|---|---|
| Was the hospitalisation related to pregnancy, abortion, sterilisation, sub-fertility or infertility?<br>☐ Yes ☐ No<br>If yes, please specify condition and approximate date of commencement: ____________________ | Had the illness been treated previously? ☐ Yes ☐ No<br>1. If yes, please provide the name and address of the attending physician<br>2. Dates of previous treatments |
| Type of operation performed, if applicable | |

| | | | |
|---|---|---|---|
| Date of Admission | Date of Discharge | Name of Hospital / Clinic | Name and address of attending physician |
| Was the hospitalisation / day surgery due to an Accident? ☐ Yes ☐ No | | Date / Time of Accident | Place of Accident |

| | |
|---|---|
| Describe how the accident happened | Describe the injuries |
| Was the Accident work-related? ☐ Yes ☐ No | Are you entitled to claim against Work Injury Compensation? ☐ Yes ☐ No |

## C. Claims Payment Details

Claim cheque to be made payable to: (please specify one only) ☐ Employer ☐ Employee

## D. Declaration and Authorisation

I / We hereby authorise any doctor(s), hospital(s) or dentist(s) or other person who has / have attended to me / us, to disclose to HSBC Insurance (Singapore) Pte. Limited any and all information with respect to my / our medical conditions(s) / treatment(s). I / We also hereby declare that the information stated in this form are true and correct.

________________________________________ ___________________________________
Employer's signature / Company's stamp / Date Employee's / Claimant's signature / Date

## Part 2: MEDICAL REPORT
## (To be completed by the Attending Physician / Surgeon)

| Name of Patient | | Policyholder (Employer) | |
|---|---|---|---|
| Policy Number | NRIC No / Passport No | Date of Birth | Sex: ☐ Male ☐ Female |

| | |
|---|---|
| 1a) Final Diagnosis | ICD Code: |
| b) Secondary Diagnosis | ICD Code: |
| c) Is the condition due to | |
| i) Congenital anomaly / Genetic or Chromosonal disorder | ☐ Yes ☐ No |
| ii) Mental or Nervous or Psychiatric disorder | ☐ Yes ☐ No |
| iii) Treatment of teeth or gum tissue or oral cavity | ☐ Yes ☐ No |
| iv) Self-inflicted injury / drug addiction / alcoholism | ☐ Yes ☐ No |
| v) Job related injury | ☐ Yes ☐ No |
| vi) Sexually transmitted disease, AIDS and illness or disease related to HIV | ☐ Yes ☐ No |
| vii) Cosmetic purpose | ☐ Yes ☐ No |
| viii) Pregnancy, childbirth, miscarriage, abortion, impotency, sterilisation, sub-fertility or infertility. If for miscarriage, was it due to accident? | ☐ Yes ☐ No<br>☐ Yes ☐ No |
| d) Is the surgery medically necessary? | ☐ Yes ☐ No |

| | |
|---|---|
| 2a) When did the patient first consulted you for the above condition / injury? | b) What was the complaint(s) when patient first see you? |
| c) How long had the patient been troubled by the symptoms prior to consulting you? | d) How long had this condition / injury been existed prior to consulting you? |
| e) Had the patient ever had same or similar condition / injury / symptoms?<br>☐ Yes ☐ No ☐ Not to my knowledge<br>If yes, when was the patient last treated for the condition / injury / symptoms? | f) Please specify the approximate date of discovery of the condition / injury. |

| | |
|---|---|
| 3a) Was the hospitalisation / day surgery due to an Accident? ☐ Yes ☐ No<br>If yes, please provide the following information: | |
| b) Date /Time of Accident | c) Place of Accident |
| d) Describe how the Accident happen | e) Describe the injuries |

4a) Was the patient being referred to you? ☐ Yes ☐ No
If yes, please the details below:

| Name of referring doctor | Date of treatments | Name of Hospital / Clinic & Address |
|---|---|---|
| | | |

| 5a) Period of Hospitalisation: | | b) Surgical Procedure Performed (if applicable): | | |
|---|---|---|---|---|
| Admission Date | Discharge Date | Surgical Procedure | Operation Code: | Operation Table: |
| Admission Date | Discharge Date | Surgical Procedure | Operation Code: | Operation Table: |

| c) Where was the surgical procedure carried out?<br><br>☐ Hospital ☐ Clinic | d) Name of surgeon(s) |
|---|---|
| e) If more than one surgical procedure had been performed, were they done through the same incision?<br>☐ Yes ☐ No | f) If excision has been done, please indicate the size(s) / /measurement(s) of the lesion(s) / tumour(s):<br>(please attach a copy of the histology report) |

Please **tick** the illness classification for the condition:

☐ Alimentary system
☐ Autoimmune disorder
☐ Cancer/Malignant tumour growth
☐ Cardiovascular system
☐ Dental
☐ Ear, Nose & Throat system
☐ Eye
☐ Genito-urinary system
☐ Gynaecological / Obstetric
☐ Haematological disorder
☐ Infectious disease
☐ Metabolic & endocrine disease
☐ Musculo-skeletal system
☐ Nervous system
☐ Psychological / Psychiatric
☐ Respiratory system
☐ Skin and subcutaneous tissue

| 6a) Is the patient still under your care for the condition?<br><br>☐ Yes ☐ No | b) If patient had been referred to another doctor for follow up, please furnish the name and address of the doctor. |
|---|---|
| If yes, how long do you expect this to continue and when is the next review date? | |
| If no, please state date of termination | |
| c) Is the condition likely to relapse or require long term care? | ☐ Yes ☐ No |

_______________________________________
Signature of Physician / Surgeon / Date

____________________________________
Stamp of Clinic / Hospital

_______________________________________
Name / Designation