FWD

GROUP HOSPITAL & SURGICAL CLAIM FORM

Important Notes:

1. The acceptance of this claim form is not an admission of liability by FWD Singapore Pte Ltd.
2. Claims should be submitted within 30 days from the date of hospital discharge.
3. Documents required
   - Inpatient claim form fully completed and signed.
   - Final and Original itemised receipts or bills, with the patient's name, date of consultation, diagnosis and treatment clearly stated.
   - Copy of referral letter from the attending GP to the Specialist/Hospital.
   - For Singapore Government/Restructured Hospitals – Inpatient Discharge Summary or Day Surgery Discharge Form.
   - For Private Hospitals – Attending Physician's Statement.
   - Copy of police report for claims involving an accident.
   - Claim settlement advice from Medisave-approved Integrated Plan (if any).
4. Submission of the claim form is not required for follow-up visits related to a prior hospitalisation/day surgery claim.
   Please indicate clearly on the bills or receipts the patient's name, NRIC/FIN and date of admission/surgery.
5. Please note that incomplete submission of documents will delay the processing of the claim.

1. Particulars of Employee

Name of Employer	
Name of Employee	
NRIC/FIN Number	Date of Birth (dd/mm/yyyy)
Occupation	Employment Start Date (dd/mm/yyyy)
Contact Number	Plan Type
Email Address	

2. Particulars of Patient (to complete if patient is spouse or child of employee)

Name of Patient	
NRIC/FIN Number	Date of Birth (dd/mm/yyyy)
Relationship to Employee ☐ Spouse ☐ Child	Marital Status ☐ Married ☐ Single
Gender ☐ Male ☐ Female	Cover Effective Date (dd/mm/yyyy)
Occupation	

3. Details of Illness or Injury

Hospitalisation due to illness

Nature of Illness/Diagnosis/Symptoms	
Type of Treatment/Operation performed	
Date symptoms first appeared (dd/mm/yyyy)	Date illness first treated (dd/mm/yyyy)
Is the illness work-related? ☐ Yes ☐ No	
Have you ever seen a doctor for any similar conditions? If "Yes" please provide details. ☐ Yes ☐ No	

Hospitalisation due to injury from Accident

Describe how it happened and state the extent of the injury (please attach a copy of the police report, if any)		
Place of Accident	Time of Accident	Date of Accident (dd/mm/yyyy)
Is the injury work-related? ☐ Yes ☐ No	Is it claimable under Workmen's Compensation? ☐ Yes ☐ No	

4. Please provide the additional information if hospitalisation/day surgery was performed outside Singapore

Purpose of the overseas trip	
Date of departure from Singapore (dd/mm/yyyy)	Date of return to Singapore (dd/mm/yyyy)

5. Other Information

Have you claimed or do you intend to claim from any other insurer, employer or third party? ☐ Yes ☐ No
If "Yes", please provide details below and submit a copy of the settlement letter or payment voucher.

Name of Party claimed from	Date claimed (dd/mm/yyyy)	Amount claimed

Payment Details:

Benefit should be made payable to ☐ Employee ☐ Employer

Payment method ☐ Cheque : Payee Name (as per bank account) ____________________

☐ Direct Credit* : Name of Bank ____________________ Swift Code __________

Account Number ____________________

Name of Account Holder ____________________

* unless otherwise provided, a copy of the bank book or bank statement which reflects the account number and account holder must be submitted for direct credit to an employee's personal account.

6. Declaration & Authorisation

a. I declare that all the information/documents provided are true and accurate to the best of my knowledge and I have not withheld any information that could affect this claim nor filed this claim with/against any other parties.

b. I authorise any person or organisation who has relevant information on this claim, including but not limited to any medical practitioner, health care provider, insurance company and investigative agencies, to release and exchange such information (including personal health information) requested by FWD Singapore Pte Ltd and/or its claims service providers.

c. I authorise FWD Singapore Pte Ltd and its claims service providers to collect, use, disclose and to exchange with the persons or organisations any information (including health information).

d. I am authorised to disclose information (including personal health information) about the insured members if this claim is made on behalf of them.

e. I further give my consent for FWD Singapore Pte Ltd to use the personal data given in this claim form or otherwise obtained and disclose such data to FWD's authorised staff, associated individuals and/or companies or any independent third parties (within or outside Singapore) who will provide claims administrative, advice and/or information or claims services in relation to this claim. I understand and give consent for FWD Singapore Pte Ltd to use my personal data for audit, business analysis, reinsurance purposes and for the purposes set out in FWD's Privacy Policy which can be found at www.fwd.com.sg.

f. I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

____
Signature of Employee

Date (dd/mm/yyyy)

____
Signature of Patient (employee to sign if patient below 21)

Date (dd/mm/yyyy)

____
Signature of Employer & Company Stamp*

Name/NRIC Number of Signatory

Date (dd/mm/yyyy)

* compulsory for headcount policies

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ATTENDING PHYSICIAN'S STATEMENT

To be completed for patients seeking treatment at Private Hospitals/Specialists Clinics/Overseas Hospitals

1. Particulars of Patient

Name of Patient

NRIC/FIN Number	Date of Birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female

2. Details of Illness or Injury

ICD 10 Code	Diagnosis of Illness/Nature of Injury	Cause of Illness/Injury (if due to an accident, please furnish date of accident)

When were you first consulted for the condition?

How long had the symptoms or illness or injury existed prior to consulting you?

What were the patient's symptoms or complaints presented during the first consultation?

Has the patient had similar or related conditions/symptoms previously? ☐ Yes ☐ No
If "Yes", please provide the nature of the problem and date symptoms first appeared.

Has the patient been treated by other doctors for the condition? ☐ Yes ☐ No
If "Yes", please specify below :

Name of Doctor	Date Consulted (dd/mm/yyyy)	Name of Clinic & Address	Diagnosis	Was it a Referral?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Was the condition or treatment related directly or indirectly to:	Yes	No	If "Yes", please give details
a. Congenital abnormalities or developmental disorders?	☐	☐	
b. Cosmetic/plastic surgery?	☐	☐	
c. Refractive error of the eye?	☐	☐	
d. Dental/gum treatment?	☐	☐	
e. Psychological, mental or emotional disorders?	☐	☐	
f. Sexually transmitted diseases, AIDS or HIV related infection?	☐	☐	
g. Alcohol, drug abuse or use of unprescribed drugs where such drugs are required by law to be prescribed by a registered doctor?	☐	☐	
h. Pregnancy, childbirth, infertility, impotence, contraception, abortion?	☐	☐	
i. Self-inflicted injuries or injuries resulting from attempted suicide?	☐	☐	
j. Treatment for obesity?	☐	☐	

3. Details of Surgical Procedures and Treatment

If surgery was performed, please provide details below:

Table*	Operation Code*	Type of Operation	Date Performed (dd/mm/yyyy)	Name of Surgeon	Name of Anesthetist

Where was the operation/surgical procedures performed? ☐ Hospital ☐ Clinic

Were the surgical procedures approached through the same incision? ☐ Yes ☐ No

* for surgery done in Singapore based on Tables of Surgical Operation for Medisave scheme, 1 Feb 1990.

If no surgery was performed, please state treatment and medication given.

Were there any diagnostic tests done? If "Yes", please enclose a copy of the test results. ☐ Yes ☐ No

In your opinion, was the surgery or treatment necessary? If "No", please give details. ☐ Yes ☐ No

4. Follow-Up Treatment

Has patient fully recovered from the condition? ☐ Yes ☐ No
If "No", what follow-up treatment is required?

Is the condition likely to relapse or require long term care? ☐ Yes ☐ No

Is the patient still under your care for the condition?

☐ No: Please state date of discharge from your care ______________________

☐ Yes: How long do you expect treatment to continue? ____________________ When will you review the patient again? __________________

If patient has been referred to another doctor for follow-up, please furnish name and clinic of doctor.

Name of Doctor	Name of Clinic	Specialty	Reason for Referral

5. Doctor's Certification

I hereby certify that I have personally examined and treated the patient for the above condition(s) and the answers given represent my medical opinion of his/her condition.

____
Signature of Doctor

Name & Designation of Doctor

Clinic/Hospital Stamp

Date (dd/mm/yyyy)