



ace insurance

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HOSPITAL INCOME PLAN CLAIM FORM



SG009

PLEASE NOTES: This claim form is to facilitate your claim in the event of you or a member of your family is confined to hospital while being insured under a Hospital Income policy.

You can help to avoid unnecessary delay in processing your claim by ensuring that:

- 1) Section A to D to be fully completed and signed by the Insured and/or claimant. Please attach the Original Detailed Pre-Medical/ Final Hospitalization/Post-Medical/a copy of the Inpatient Discharge Summary to the Claim Form
- 2) Section E is to be completed by the claimant's attending physician. Please note that you or the claimant is responsible for any expenses incurred in obtaining medical evidence in support of the claim.

The issue and acceptance of this form does NOT constitute an admission of liability by the Company or waiver of its rights.

SECTION A: PARTICULARS OF POLICYHOLDER/INSURED PERSON

Name of Policyholder/Insured Person :	Policy No. :	Period of Insurance:
Address :	NRIC No. :	Tel No. (Office) :
	Date of Birth:	Tel No. (Residence) :
Occupation :	Age:	E-mail Address :
Date of Employment:	Sex : <input type="checkbox"/> Male <input type="checkbox"/> Female	Name of Intermediary (if any) :
	Bank or Card Account Number (through which premiums are charged):	

SECTION B: PARTICULARS OF CLAIMANT

Name of Claimant (If different from Insured Person):	NRIC No.:	Date of Birth :
Sex : <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation :	Industry of Business :
		Relationship to Insured :

SECTION C: DETAILS OF CLAIM

1. PLEASE COMPLETE IF HOSPITALIZATION WAS DUE TO ACCIDENT

a) Date and Time of a Accident :	b) Nature of Injury (e.g. fracture, cut, bruise etc) :
c) Chronology Event of the Accident :	
d) Name of Hospital :	e) Period of Hospitalization: From : _____ To : _____

2. PLEASE COMPLETE THIS PORTION IF HOSPITALIZATION WAS DUE TO AN ILLNESS

a) Date of Symptoms first noticed :	b) Date of first consultation with a medical practitioner for this condition. : _____
c) Nature of Illness (<i>describe the symptoms suffered</i>) :	d) Has the claimant ever seen a doctor for any similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If ' Yes ', Name & address of clinic/hospital: _____ _____ _____ Name of doctor: _____ Tel & fax: _____
	e) Name of Hospital :

SECTION D: ANY OTHER INSURANCES

Are you claiming from any other insurance company or other sources in respect of injury or illness? If yes, state :

<u>Name of Insurance Company</u>	<u>Policy No.</u>	<u>Amount of Benefits</u>	<u>Date Insurance Effected</u>
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DECLARATION AND AUTHORIZATION

- 1) I/We declare that the above information is true and complete to the best of my/our knowledge and belief.
- 2) I/We hereby authorize any doctor or any other person who has ever medically attended to the Claimant, or any Hospital in which he or she has been treated to disclose any relevant knowledge or information which they acquired, to ACE Insurance Limited or their Authorized Representative.
- 3) I/We hereby request and authorize ACE Insurance Limited to pay benefit due in respect of this claim to: _____
 (other than insured)
- Claimant's Signature : _____ Insured's Signature : _____ Date : _____

Note: If (a) The Insured is claiming on his own belief or (b) the Claimant concerned is a Child under 18 years of age – only the Insured's signature is required.

SECTION E: ATTENDING PHYSICIAN'S STATEMENT (TO BE COMPLETED BY ATTENDING PHYSICIAN)

1. Name of Patient :	2. I.C. No.:	3. Date of Birth :
4. a) If Injury : When did Accident occur? b) If Sickness : When did symptoms first appear	a) b)	
5 a) State the Nature of Injury or Sickness (<i>Describe complications – if any</i>) b) Final Diagnosis : c) Nature of Surgery (<i>if any</i>).	a) b) c)	
6 a) When did the Patient first receive medical attention for this condition b) By whom and the name & address	a) b)	
7. Has the Patient ever had this or any similar condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes. If 'yes', details _____ _____ _____	
8. Is the present condition due to (a) congenital anomaly? (b) nervous or mental disorder? (c) pregnancy/childbirth/infertility? (d) alcohol influence?	a) <input type="checkbox"/> No <input type="checkbox"/> Yes, specify: _____ b) <input type="checkbox"/> No <input type="checkbox"/> Yes, specify: _____ c) <input type="checkbox"/> No <input type="checkbox"/> Yes, specify: _____ d) <input type="checkbox"/> No <input type="checkbox"/> Yes, specify: _____	
9. (a) Name and address of Hospital Admitted (b) Period of Hospitalization	a) b) From _____ To _____	
10. Are you the patient's usual doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, name and address of usual doctor: _____ _____	

I hereby certify that I have personally examined and treated the patient for the above injury/sickness and that the facts as given above present my opinion of his/her condition.

Name of Physician : _____ Qualification : _____
 Official address : _____ Tel : _____
 _____ Fax : _____
 Signature with official stamp : _____ Date : _____