

DOMESTIC MAID INSURANCE MEDICAL CLAIM FORM

To help us expedite your claim, please complete this form ([including Attending Doctor's Statement](#)) fully and return together with a copy of the Certificate of Insurance, a copy of the maid's work permit, a copy of the employment contract, original medical invoices, receipts and discharge summary within 30 days of discharge from the hospital.

Part I – To be completed by Employer and Patient (Maid)

PARTICULARS OF INSURED			
Name of Employer		NRIC/Passport No.	
Policy No./Insurance Certificate No.		Contact Person/Telephone No.	
Address			
PARTICULARS OF PATIENT (MAID)			
Name of patient (Maid)		Date of employment	
Marital status	Nationality	Date of birth	Sex
MEDICAL CONDITION OF PATIENT (MAID)			
Illness (Please provide details of illness [including description of symptoms] and attach hospital discharge summary for our reference. For female who was pregnant at time of hospitalisation, please state the number of months of pregnancy.)		Accident (Please provide details on extent of injury & circumstances of the accident. Please also attach accident report.)	
Date which symptoms first appeared	Duration of symptoms	Date of accident	Time of accident
Name and Address of attending Doctor		Did you have any surgical operation due to this Illness / Accident?	If yes, when was the operation? (DD/MM/YYYY)
Name and Address of referral Doctor / any other Doctor consulted		Name and Address of regular Doctor	
OTHERS			
Please advise the amount of government levy that the Insured (employer) pays monthly.			
Are you entitled to or claiming reimbursement from any Insurance Company? If yes, please provide the following information :			
Name of Insurance Company	Policy Number	Claim Amount	
DECLARATION / AUTHORISATION			
I hereby declare that the above statements are true and complete to the best of my knowledge. I give consent to Allianz Insurance Company of Singapore Pte Ltd to seek information from any doctor, hospital or organisation and authorise the provision of such information. A photocopy of this authorisation shall be treated as a valid document.			
Signature of Patient (Maid)		Date	
I hereby declare that the foregoing particulars are true and correct.			
Signature of Employer		Date	

ATTENDING DOCTOR'S STATEMENT

THIS ATTENDING DOCTOR'S STATEMENT IS TO BE COMPLETED AT THE CLAIMANT'S EXPENSE IN ACCORDANCE WITH CONDITION 6C OF THE POLICY

Part II (to be completed by attending Doctor / Surgeon)

Name of patient	NRIC/Passport No.	Date of birth
Name of hospital (admission)	Admission date	Date of discharge
Dates of first consultation and subsequent consultations	Symptoms presented by Patient	
Did the patient have any symptoms prior to consulting you? If yes, please specify the date which the symptoms first started prior to the date of first consultation with you. <input type="checkbox"/> Yes : Date _____ <input type="checkbox"/> No <input type="checkbox"/> Not to my knowledge	How long has the illness/injury been existing prior to the date of first consultation with you?	
Has patient ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not to my knowledge	What is the cause of illness/injury?	Date of diagnosis
		Diagnosis of illness or extent of injury
Treatment (s) provided	Surgery performed	Surgery Date (DD/MM/YY)
	_____	___/___/___
	_____	___/___/___
	_____	___/___/___
Please provide Name and Address of the Doctor(s) who had treated the Patient previously or referred Patient to you.		
Was the condition of the Patient due to the following (please tick):	Yes	No
1. Congenital anomaly or genetic defects present at birth.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Study and treatment of sleeping disorder	<input type="checkbox"/>	<input type="checkbox"/>
3. Dental treatment	<input type="checkbox"/>	<input type="checkbox"/>
4. Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>
5. AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>
6. Functional disorder of the mind or nervous mental disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
8. Drug addiction	<input type="checkbox"/>	<input type="checkbox"/>
9. Cosmetic or plastic surgery	<input type="checkbox"/>	<input type="checkbox"/>
10. Pregnancy, child birth, infertility or sub-fertility, miscarriage, abortion.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Self inflicted injuries	<input type="checkbox"/>	<input type="checkbox"/>
Signature & Stamp of Doctor		(If "Yes", please provide details.)
Name and Address of Practicing Clinic		
Name of Doctor	Date	