

HOSPITALISATION & SURGICAL INSURANCE CLAIM FORM

To help us expedite your claim, please complete this form fully (including [Attending Doctor's Statement](#)) and return together with the original medical invoices, receipts and discharge summary within 30 days upon discharge from the hospital.

Part I – To be completed by Policyholder and Insured Person (Patient)

PARTICULARS OF POLICYHOLDER				
Name of Policyholder		Contact Person/Tel No.		
Policy No.		Are you GST registered at the commencement of the Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Policyholder's Signature & Company Stamp (if applicable)		Payment cheque to be made payable to (please tick) :		
Date :		<input type="checkbox"/> Policyholder <input type="checkbox"/> Others : <input type="checkbox"/> Insured person (including MediSave)		
PARTICULARS OF INSURED PERSON (PATIENT)				
Name of Insured Person		NRIC/Passport No.		Date you joined the Company (for Group policy)
Occupation	Relationship to Policyholder	Contact No.	Date of Birth	Sex
MEDICAL CONDITION OF INSURED PERSON				
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 and Time of Accident	Is this a job related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name and Address of attending Doctor(s)		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 or other Doctor consulted		Name and Address of your regular Doctor		
OTHERS				
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 release of such information. A photocopy of this authorisation form shall be treated as a valid document.				
Signature of Insured Person or Claimant (if Insured Person is aged below 21 years old)		Relationship of Claimant to Minor		Date

ATTENDING DOCTOR'S STATEMENT

THIS ATTENDING DOCTOR'S STATEMENT IS TO BE COMPLETED AT THE CLAIMANT'S EXPENSE IN ACCORDANCE WITH THE TERMS AND CONDITIONS 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?	Diagnosis of illness or extent of injury	Date of diagnosis	Date which you informed patient of diagnosis		
What is the cause of illness/injury?		Test/Treatment/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):				(If "Yes", please provide details.)	
		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		Name and Address of Practicing Clinic			
Name of Doctor	Date				