中国太平保险(新加坡)有限公司
CHINA TAIPING INSURANCE (SINGAPORE) PTE. LTD.
3 Anson Road #16-00 Springleaf Tower Singapore 079909
Tel: 6389 6111 Fax: 6222 1033
Website: www.sg.cntaiping.com
Co. Reg. No. 200208384E

Foreign Workers' Medical Insurance Claim Form

1 – Particulars of Insured

Name of Company (Policyholder)			Policy No.	Plan Type
Name of Insured Person / Employee			NRIC / Passport No.	Date of Birth
Gender ☐ F ☐ M	Marital Status ☐ S ☐ M	Occupation	Effective Date of Insurance	Contact Nos. (Off) (HP)

2– Details of Illness or Injury

(Impt:please include a copy of inpatient discharge summary for Government Restructured Hospital claims)

A. Hospitalization due to Illness		B. Hospitalization due to Injury from Accident		
Diagnosis & Symptoms Type of Operation performed (if applicable)		Describe how it happened and state the extent of the injury		
Date symptoms first appeared	Date illness first treated	Date of Accident	Time of Accident	Place of Accident
Is the illness work-related? ☐ No ☐ Yes Is the illness due to pregnancy, miscarriage or fertility? ☐ No ☐ Yes		Is the injury/accident work-related? ☐ No ☐ Yes Is it claimable under Workmen's Compensation? ☐ No ☐ Yes		

3 – Other Information

Are you making a claim from any other insurance companies?

☐ No ☐ Yes, please provide information below :

Name of insurance company ..... Type of Policy .....

Policy No .....

*Please submit a copy of the other insurance company's claim settlement letter or payment voucher

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4. DATA PRIVACY STATEMENT

In accordance with the Personal Data Protection Act 2012, I consent to the collection, use, disclosure of and/or process of my personal data (whether contained in the Claim Form or otherwise obtained) by China Taiping Insurance (Singapore) Pte Ltd, its affiliates and service providers (within or outside Singapore), for the purpose relating to the evaluation of the claim and to provide advice and information relating to the claim to me by Short Message Service (SMS), Multimedia Messaging Service (MMS) and fax messages (notwithstanding the registration of my telephone or mobile number in the Singapore's Do Not Call Registry)

Yes, I have read and agreed to the above Data Privacy Statement.

X
… ……..
Signature of Claimant

Name: ……..

NRIC/FIN/Passport No……..

4 – Declaration & Medical Authorization

1. I declare that the above statements and answers are true and complete to the best of my knowledge and belief.
2. I hereby authorize any hospital, physician, person or organization to disclose when requested to do so by China Taiping Insurance (Singapore) Pte Ltd, all information with respect to any illness, injury, medical history, consultations, prescription or treatments and copies of all hospital or medical records.
3. A photocopy of this authorization shall be considered as effective and valid as the original.

X	X	X
Signature of Insured Person / Employee	Signature of Patient / Guardian (to be signed by parent or guardian if below 21)	Signature of Employer / Company's Stamp
Date :	Date :	Date :