Hospital Income Plan

Claim Form

SG020

CHUBB®

Important Information

This claim form is to facilitate your claim in the event of you or a member of your family is being 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) Sections A to E are fully completed and signed by the Insured and/or Claimant.

2) Section F is 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.

3) If you are claiming for Recuperation / Post-Hospitalisation benefits, please attach detailed Pre-Medical / Final Hospitalisation / Post-Medical Report or a copy of the Inpatient Discharge Summary to the Claim Form.

4) If you are claiming for Medical / Hospital expenses, please attach the original detailed Final Bills and Receipts.

The issue and acceptance of this form does NOT constitute an admission of liability by Chubb Insurance Singapore Limited (Chubb) or waiver of its rights.

Section A: Particulars of Policyholder / Insured Person

Name of Policyholder / Insured Person (as shown in NRIC / Passport)

_____

Address of Policyholder / Insured Person

_____

_____ Postal Code_____

Policy No (s)

_____

Period of Insurance From DD / MM / YYYY To DD / MM / YYYY

NRIC / Passport No. _____ Date of Birth DD / MM / YYYY

Nationality _____ Age _____

Tel No. (Mobile) _____ Gender ☐ Male ☐ Female

Tel No. (Residence) _____ Tel No. (Office) _____

Email _____

Name of Intermediary (if any) _____

Name of Employer _____

Occupation _____ Date of Employment DD / MM / YYYY

Name of Claimant (as shown in NRIC / Passport) - if different from Insured Person

_____

Address of Claimant

_____

_____ Postal Code_____

NRIC / Passport No. _____ Date of Birth _____

Nationality _____ Age _____

Tel No. (Mobile) _____ Gender ☐ Male ☐ Female

Tel No. (Residence) _____ Tel No. (Office) _____

Email _____

Relationship to Insured _____

Name of Employer _____

Occupation _____ Date of Employment DD / MM / YYYY

Section B: Payment Details

Please provide details for payment of your claim in the event that the claim is deemed payable by Chubb.

I hereby authorise and request Chubb to pay benefit due in respect of this claim as follows (Name as per Identification Card and / or Bank Account):

☐ Cheque Payment

Payee Name (as per bank account name) _____

☐ Electronic Funds Transfer (for payments in SGD and to bank accounts in Singapore)

Payee Name (as per bank account name) _____

Name of Bank _____

Branch Code No. _____ Account No. _____

If no name is provided, settlement will be effected to the payee as provided for under the terms of the policy.

Section C: Details of Claim

Name of Hospital _____

Period of Hospitalisation From DD / MM / YYYY To DD / MM / YYYY

Was the Insured referred by a General Practitioner / Specialist / Other Hospital? ☐ Yes ☐ No
If **Yes**, please provide details below:

Name of General Practitioner / Specialist / Hospital

_____

Address

_____

_____ Postal Code _____

Please complete this portion if hospitalisation was due to accident

Date of the Accident DD / MM / YYYY Time of the Accident (24-Hour) H H : M M

Country of Accident _____ Place of Accident _____

When and Who discovered the Accident _____

Relationship of person to the Insured _____

Were there witnesses to the accident? ☐ Yes ☐ No
If **Yes**, please provide details below:

	Witness 1	Witness 2
Name		
Address		
NRIC		
Contact Number		

Was the Insured under the influence of alcohol, medication, drugs or any other intoxicating substance at the time of accident? ☐ Yes ☐ No
If **Yes**, please provide details below (Please use supplementary sheet if necessary):

Name/Type of Alcohol, Medication, Drugs or Intoxicating Substances	Quantity Consumed	Date And Time Consumed

Nature of Injury (e.g. fracture, cut, bruises, etc) _____

Chronology and Description of the Accident (Please use supplementary sheet if necessary)

_____

_____

_____

_____

Please complete this portion if hospitalisation was due to an illness

Details of the Medical Practitioner who is currently treating the Insured

Name of Clinic / Hospital _____ Name of Doctor_____

Address

_____

_____ Postal Code_____

Tel / Fax_____

Nature of Illness (describe the symptoms suffered)

_____

_____

_____

Date of Symptoms First Noticed DD / MM / YYYY

Date of First Consultation with a Medical Practitioner for this Condition DD / MM / YYYY

Describe the symptoms presented during the first consultation

_____

_____

_____

Has the Insured ever seen a doctor for any similar condition in the past? ☐ Yes ☐ No
If **Yes**, please provide details of the Clinic / Hospital

Name of Clinic / Hospital _____ Name of Doctor _____

Address

_____

_____ Postal Code_____

Tel / Fax _____

Section D: Any Other Claims / Insurance

Have you claimed or are there any other insurance policies that cover or may provide cover for hospitalisation, whether for this incident or in the past? If **Yes**, state:

Name of Insurance Company	Policy No.	Type of Policy	Date Policy Effected

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

Name of Insurance Company	Policy No.	Amount of Benefits	Date Policy Effected

Section E: Declaration

Did you remember to enclose the following? (Where applicable)

Document	Yes	NA
Traffic Police Report (if involved in Road Accident)	☐	☐
Copy of Final Hospital Bill	☐	☐
Written notes from Physician on type of injury sustained / Inpatient Discharge Summary or Medical Report	☐	☐

By signing this form, I / We agree that Chubb will use the information supplied here and during the formation and performance of this policy, for policy administration, customer services, claims handling and fraud analysis and prevention, and that Chubb may disclose such information to its service providers, agents, authorities and other parties for these purposes.

I / We hereby authorise any hospital, physician, and any other person or entity who has attended to or examined the Insured, to furnish to Chubb or its authorised representatives, any and all information with respect to any illness or injury or loss, medical history, consultation, prescriptions or treatment, copies of all hospital, medical or other records, investigation status and results, and such personal information as Chubb in its absolute discretion considers relevant for its assessment of this claim. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

I / We do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I/We agree that if I / We have made or in any further declaration or representation shall make any false or fraudulent statements or suppress, conceal or falsely state any fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past, present or future claims shall be forfeited.

_____
Signature of Claimant

_____
Signature of Insured Person
(if different from Claimant)

_____
Date

Note:

Kindly submit the completed claim form in person or by mail to Chubb Insurance Singapore Limited at 138 Market Street #11-01 CapitaGreen Singapore 048946. Please ensure that the relevant original copies of supporting documents are submitted as well.

Contact Us

Chubb Insurance Singapore Limited
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138 Market Street
#11-01 CapitaGreen
Singapore 048946
O +65 6398 8000
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www.chubb.com/sg

Section F: Attending Physician's Statement (To be completed by attending physician)

Name of Patient _____

NRIC / Passport No. _____ Gender ☐ Male ☐ Female Date of Birth DD / MM / YYYY

If Injury, when did Accident occur? DD / MM / YYYY If Sickness, when did symptoms first occur? DD / MM / YYYY

State the Nature of Injury or Sickness (Describe the complications - if any)

_____

_____

_____

Final Diagnosis _____ Nature of Surgery (if any) _____

If there is more than one diagnosis, please advice whether they are directly or indirectly related to each other. (Please provide details)

_____

_____

_____

When did the Patient first received medical attention for this condition? DD / MM / YYYY

By who and where? (Please provide details below)

Name of Clinic / Hospital _____

Address _____

Name of Doctor _____

Has the Patient ever had this or any similar condition? ☐ No ☐ Yes (Please provide details below)

_____

_____

_____

What was the underlying cause(s) of the diagnosed condition(s)?

_____

_____

_____

Did the Patient receive any treatment for the condition(s) prior to consulting you? ☐ No ☐ Yes

If 2 or more surgical procedures were performed, were they performed through a single incision? ☐ No ☐ Yes

Is the present condition due to:

congenital anomaly? ☐ No ☐ Yes (Please specify)_____

nervous or mental disorder? ☐ No ☐ Yes (Please specify)_____

pregnancy/childbirth/infertility? ☐ No ☐ Yes (Please specify)_____

alcohol influence? ☐ No ☐ Yes (Please specify)_____

Were the condition(s) or treatment directly or indirectly related to each other? (Please provide details)

_____

_____

_____

Name of Hospital admitted _____

Address of Hospital admitted _____

Period of Hospitalisation From DD / MM / YYYY To DD / MM / YYYY

Are you the Patient's usual doctor? ☐ No ☐ Yes

If **No**, please provide details of the usual doctor

Name of Doctor _____ Tel / Fax _____

Address of Doctor

_____

_____

Has the Patient fully recovered from the condition(s)? ☐ No ☐ Yes

If **No**, please provide details of the follow-up treatment(s) required

_____

_____

_____

_____

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 / Field of Expertise

Official Address

_____

_____

Tel / Fax _____

_____ _____

Signature with Official Stamp Date

Chubb. Insured.℠

Published 04/2016.