ERGO

DOMESTIC MAID INSURANCE MEDICAL CLAIM FORM

This form is issued without admission of liability and must be completed and returned after completion of treatment. No claim can be considered unless the MEDICAL CERTIFICATE OVERLEAF is completed at the policyholder's expense.

1 POLICYHOLDER _____ LETTER OF GUARANTEE NO. _____

ADDRESS _____ MASTER POLICY NO. _____

TEL (MOBILE) _____ RESIDENCE/OFFICE _____

2 PERSON UNDER TREATMENT _____

DATE OF BIRTH _____

3 (a) Nature of illness/Injury (b) Description of circumstances leading to the accident (c) Where / When did it commence?	
4 Name and address of the Doctor whom he/she first consulted	
5 Name and address of his/her usual Doctor	
6 Has he/she ever suffered before from the illness/injury in respect of which you are claiming?	
7 Have you peviously claimed or received compensation under an Accident or Hospitalization Policy? If so, give particulars	
8 (a) Are you insured elsewhere? (b) If so, give the names of Company/Insurer and amounts you are entitled to claim	

I claim the amount of S$ _____ being expenses incurred by me for treatment accordance with the particulars above and receipted bills attached.

I/We hereby declare that the foregoing particulars are true and correct, that no information has been withheld and that the amount claimed is an accurate assessment of the suffered.

I/We hereby authorize any hospital, clinic, physician or any other person to disclose all information including copies of all hospital or medical records on the patient when requested by ERGO Insurance Pte Ltd. With respect to any illness, injury, consultations, medical history, prescriptions or treatment. A Photostat copy of this authorization shall be considered as effective and valid as the original.

Signature of Patient/Employee _____ Signature of Employer/Policyholder _____

Date _____ Date _____

The questions overleaf must be answered by a registered Medical Practitioner.

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MEDICAL CERTIFICATE

Please State:

1	Full name of Patient	
2	What illness/injury the Patient has sustained	
3	The date you first attended the Patient in respect of the illness/injury	
4	Whether you are still attending the Patient?	
5	How the illness/injury were sustained?	
6	What previous illness / injury / disease / disability the Patient suffered from that caused or contributed to the illness / injury	
7	Details of any permanently disability the Patient sustained as a result of the illness/injury	
8	Full particulars of the operation illness or injury and the cause	
9	Name and address of the hospital/nursing home in which the Patient has been treated	

I hereby certify that the foregoing statements are correct.

Date _____ Signature _____

Qualification _____

Name _____

Address _____

DATA PRIVACY STATEMENT

In accordance with the Personal Data Protection Act 2012, I/We consent to the collection, use, disclosure of and/or process my/our personal data (whether contained in the Claim Form or otherwise obtained) by ERGO Insurance 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/us by Mail, Email and fax messages (notwithstanding the registration of my/our telephone number(s) in the Singapore's Do Not Call Registry).

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

Signature _____

Name _____

NRIC/Passport No. _____

DECLARATION AND AUTHORIZATION

I/We hereby declared the foregoing answers to be true and correct in every respect to the best of knowledge and no information or particulars have been suppressed.

_____ _____

Signature of Insured(with company stamp) Date (dd/mm/yyyy)