

Tenet Insurance Company Ltd

(A member of Sompo Japan Group)
50 Raffles Place #05-01/06 Singapore Land Tower Singapore 048623
Tel: 6221 2211 Fax: 6221 3302
Company Registration No. 195700067Z http://www.tenetinsurance.com



FOREIGN WORKER MEDICAL CLAIM FORM

Important Notice :

- 1 The acceptance of this form is NOT an admission of liability on the part of the Company.
- 2 All original final bills, certificates, supporting documents should be provided to substantiate your claim.
- 3 All medical reports must be submitted at the claimant's expense before a claim can be admitted.
- 4 Please answer in full all applicable questions as incomplete answers may delay claims settlement.

What documents do I need to submit?

- ◆ Fully completed claim form
- ◆ Medical reports and / or In-Patient Discharge Summary Form
- ◆ Original medical bills and final hospital bills

Useful notes

- ◆ Please ensure that the hospital bill submitted is the Final bill. An interim bill will not give an accurate figure for the hospitalization bill and we will not be able to make payment based on the interim bill.
- ◆ At the minimum you should provide the In-patient Discharge Summary as this will give an indication of the medical condition sustained.
- ◆ If the information on the IDS is not sufficient we may request for additional information and / or the Medical Certification form to be completed by the attending doctor. The cost of any medical report will be borne by the insured.

Agency _____ Policy No _____

1. INSURED'S PARTICULARS

a. Name of Insured

b. Address

c. Contact Nos. / Contact person

Contact person _____ (O) _____ (HP) _____

2. WORKER'S PARTICULARS - please attach copy of the worker's passport and work permit or identity card

a. Name of worker

NRIC / Passport No. of Claimant: _____ Nationality _____

b. Female Male / Age _____ Date of birth _____ / Contact No: _____

c. State worker's date of employment and occupation

Date: _____ Occupation: _____

3. DETAILS OF ILLNESS / INJURY

a. Describe what happened (if insufficient space, please attach statement).

b. Nature of Illness (describe symptoms suffered) / Injury (eg, fracture, cut, bruise etc.)

c. When did symptoms first commence / Date of Accident: _____

When was condition first treated: _____

d. Are you still being treated? Yes No.

e. Any more bills to be submitted? Yes No.

f. Have you consulted a doctor or been treated for any similar condition in the past? Yes No

If yes, kindly give more details including date of previous treatment and name and address of attending doctor for previous treatment.

g. Is injury work related: Yes No

4. PAYMENT DETAILS

a. Please confirm payee name if claim is payable _____

We may request for your doctor to complete the Medical Certificate of Treatment Form if more information on the medical condition is required.

DECLARATION AND AUTHORISATION - to be signed by the claimant

I declare that the particulars stated above are true and correct and I understand that if I have in this or in any further declaration in respect of this claim, made any false or fraudulent statement or suppress conceal or falsely state any material fact whatsoever my claim may be refused. I/We further authorise the Company to treat the submission of this form as my/our making a claim under my/our policy.

I hereby authorize any hospital physician, other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photocopy of this authorisation shall be considered as effective and valid as the original.

Signature of Worker

Date

Authorized signature and chop of Insured

Date