HOSPITALIZATION & SURGICAL CLAIM FORM

The issue and acceptance of this form and its accompanying documents (if any) does NOT constitute an admission by ERGO Insurance Pte. Ltd. that any part or the whole of the Claimant's claim is accepted. It also does not constitute a waiver of ERGO's rights in accordance with the terms and conditions of the Policy. Any documentary proof or report required by the Company shall be furnished at the expense of the Policyholder or Claimant.

This form must be completed truthfully and accurately, please answer in full all applicable questions. The list of documents required is not exhaustive and we reserve our right to request from you any additional information/ supporting documentation, as necessary. The submission of an incomplete form or insufficient information or supporting documents may delay the claims processing or result in the denial of your claim.

The completed form should be returned together with all supporting documents as soon as possible to the following address:

Claims Department
ERGO Insurance Pte. Ltd.
5 Temasek Boulevard
#04-05 Suntec Tower Five
Singapore 038985

In the event that this claim is deemed payable by us, it shall be payable to the relevant Policyholder/Employer or Claimant/Employee only and not to third parties.

PART I - STATEMENT BY PATIENT AND EMPLOYEE

1 (a) Patient's Name _____

(b) Sex ☐ Male ☐ Female (c) Date of birth _____

(d) NRIC/Fin No./Passport No. _____

(e) Patient's relationship to employee _____

(d) Email _____

Please provide your bank details for us to accelerate your claims payment process by direct transfer to your bank account.

Name (as per bank account) _____

Bank Name _____

Account No. _____

Notification of payment will be sent to your email address stated in your details. The company shall :
(i) be discharged from all liability under this claim and
(ii) not be liable for any and all losses incurred by you, as a result of you providing the company with inaccurate bank account number under this section for the payment of this claim.

2 If Patient is not the Employee, please complete:

(a) Employee's Name _____

(b) Sex ☐ Male ☐ Female (c) Date of birth _____

(d) NRIC/Fin No./Passport No. _____

(e) Did sickness/accident arise from employment ☐ Yes ☐ No

(f) Patient's Employer (if any) _____

3 SICKNESS

(a) Nature of sickness _____

(b) Date of sickness first begin _____ (c) Date first treated _____

(d) Was this condition treated previously? ☐ Yes ☐ No (e) Name of Doctor _____

(f) Address of Doctor _____

(g) Did this doctor refer you on his own accord to the Specialist who is now treating you? ☐ Yes ☐ No
If Yes, please attach Doctor's referral letter.

4 ACCIDENT

(a) Date of accident _____ (b) Time _____

(c) Describe how and where accident happen

_____

_____

_____

5 OTHER INSURANCE

(a) Is the Patient entitled to claim against Workmen's Compensation Benefits or other Medical Benefits?

☐ Yes ☐ No

If Yes, please state Insurance Company _____

PART II - STATEMENT BY EMPLOYER

1 Name of Employer _____

2 (a) Name of Employee _____

(b) Certificate No. _____

(c) Present Occupation _____

(d) Date of Employment _____

(e) Benefit Catergory _____ (e.g. Exempt, Non Exempt, Managerial, Executive etc)

3 (a) Effective date of Employee's medical insurance _____ (b) Plan Type. _____

4 If Patient is the spouse or child, please complete:

(a) Effective date of dependant's coverage _____ (b) Plan Type. _____

Cheque payable to Amount(S$)

1 CPF Medisave A/C No. _____ _____

2 _____ _____

3 _____ _____

PART III - MEDICAL REPORT BY ATTENDING PHYSICIAN/SURGEON PLEASE COMPLETE THIS FORM AND RETURN TO ERGO INSURANCE PTE. LTD.

Name of Patient _____

Age _____ Sex ☐ Male ☐ Female

1 (a) Nature of sickness or injury (if fracture or dislocation, describe nature and location)

_____

(b) Is condition a congenital anomaly, nervous or mental disorder? ☐ Yes ☐ No
If Yes, explain.

_____

(c) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No
If Yes, explain.

_____

(d) Is condition due to Pregnancy or Infertility or Childbirth? ☐ Yes ☐ No
If Yes, what was the approximate date of commencement of pregnancy?

_____

2 (a) Has Patient had same or similar condition? ☐ Yes ☐ No

_____

(b) When did symptoms first appear or accident happen? _____

(c) When did Patient first consult you for this condition? _____

3 (a) Nature of surgical or obstetrical procedure (if any) (Describe fully)

_____

(b) Date of operation. _____

4 Give dates of other medical (non-surgical) treatment. (if any) _____

5 What other services, if any, did you provide patient? (itemize giving dates and fees) _____

_____

6 Is patient still under your care for this condition? ☐ Yes ☐ No

If No, give date your services terminated _____

7 Name of physician previously consulted by patient _____

Date	Signature (Physician/Surgeon)	Qualification	Telephone

DECLARATION, AUTHORIZATION AND PERSONAL DATA PROTECTION STATEMENT

[**Declaration**] I/ We declare that the particulars stated above are true, accurate and complete 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.

[**Authorization**] Where applicable, 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. (ERGO). I have noted that any illness, injury, consultations, medical history, prescriptions or treatment the medical report fee incurred will be borne by me. A copy of this authorization shall be considered as effective and valid as the original.

[**Personal Data Protection Statement**] I/We understand, acknowledge, agree and consent that:

a. ERGO Insurance Pte. Ltd. (ERGO) may/will collect, use, disclose and/or process my/our personal data set out in this form and any other information provided by me (including that provided from sources other than myself) or possessed by ERGO for the purpose of enabling ERGO to provide me with services required of an insurance provider, such as evaluating, processing, administering, and/or managing of my relationship and policies with ERGO. This includes among other things policy servicing, processing, investigating, handling, administering and/ or settling my/our claim with ERGO or other insurers;
b. ERGO may/will disclose and transfer my/our personal data to third parties, including but not limited to its affiliates, representatives, agents and third party service providers, lawyers/law firms, whether located within or outside Singapore, for one or more of the above purposes, and the said third parties may/ will subsequently collect, use, disclose and/or process my/ our personal data for or more of the above purposes;
c. The personal data protection clauses herein are not exhaustive. I/We have read, understood and accept the terms of ERGO's Personal Data Protection Policy at https://www.ergo.com.sg/pdpa;

If I/We provide personal data of a third party (e.g. information of insured persons, beneficiaries, beneficial owners, dependents, customers, payees and/ or employees) to ERGO, I/We represent and warrant to ERGO that prior consents have been obtained from each of the third parties to provide such information.

Name of Claimant	NRIC/FIN/WORK PERMIT No.
Signature of Claimant	Date (DD/MM/YYYY)
Signature of Policyholder (Name of employee and Company's stamp)	Date (DD/MM/YYYY)