RafflesHealthInsurance
Your Specialist Health Insurer

RAFFLES SHIELD CLAIM FORM

IMPORTANT NOTES: It is important to read the notes below before you complete the claim form.

PREPARING REQUIRED DOCUMENTS
Please complete this form in **FULL** and submit the following documents within 90 days of discharge from the hospital or visit to clinic:

- Original Final Summary and Itemised Hospital Bills. (Photocopied / Interim / Certified True Copy / Duplicate bills are not acceptable)
- For Government Restructured Hospitals: Inpatient Discharge Summary / Day Surgery Discharge Form / Histology Report
- For Overseas Hospitals / Private Hospitals / Clinics: Attending Physician's Statement (refer Page 4)
- Please note that this form is **NOT** an acceptance of your claim.
- Please note that incomplete submission of documents may delay the processing of your claims.

SECTION 1: PARTICULARS OF POLICYHOLDER / PAYOR

Name of Policyholder			NRIC / FIN / Passport No	Policy No.
Gender ☐ Female ☐ Male	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Occupation	Date of Birth (DD/MM/YYYY)	Contact Nos. (Office) (Handphone)
Address			Email Address	

SECTION 2: PARTICULARS OF INSURED (If different from Section 1)

Name of Insured		NRIC / FIN / BC / Passport No.	Date of Birth (DD/MM/YYYY)
Gender ☐ Female ☐ Male	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Occupation	Relationship to Policyholder ☐ Spouse ☐ Child ☐ Others (Please Specify)

SECTION 3: DETAILS OF ILLNESS OR INJURY

Treatment type: ☐ Inpatient ☐ Day Surgery ☐ Short Stay Ward ☐ Pre/Post Hospitalisation Treatment
☐ Outpatient Chemotherapy/radiotherapy/immunotherapy ☐ Outpatient Renal Dialysis

(Please tick the box as appropriate)

Admission Date (DD/MM/YYYY)	**Discharge Date** (DD/MM/YYYY)
A. Hospitalisation due to Illness • **Nature of Illness/Final Diagnosis** Date of Diagnosis: • **Secondary Diagnosis** Date of Diagnosis: **Describe Symptoms and date symptoms first appeared** **Type of Operation performed (if applicable)** Date of Operation:	**B. Hospitalisation due to Injury from Accident** Describe how it happened and state the extent of the injury (Please enclose a copy of the police report, if any.) _____ _____ _____ _____ _____ _____ _____

Date illness first treated/Date of first consultation (DD/MM/YYYY)	Date of Accident (DD/MM/YYYY)	Time of Accident (HH : MM)	Place of Accident
Name of doctor/hospital the patient first consulted for the illness	Is the injury/accident job-related? ☐ No ☐ Yes Is it claimable under Work Injury Compensation Insurance? ☐ No ☐ Yes ***If Yes, please complete Section 5***		

SECTION 4: POLICYHOLDER'S BANK ACCOUNT DETAILS (PAYOR)

☐ **Please tick if there is any change of bank account**

Name of Bank: ..... Bank Code: ..... Branch Code: ..... A/C No.: ....

Note: 1. If this is your first claim, please provide a copy of bank statement or bank book showing policyholder name and bank account number.
2. We will update the bank account number for future claims under this policy.

SECTION 5: OTHER INSURANCE DETAILS

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.
- ***Insured should claim from any Company's Insurance/ Personal Insurance, first.***

Important Note:
Where applicable, any party who is under a contractual obligation to reimburse the medical expenses of the above hospitalisation or day surgery is required to reimburse to the Integrated Shield Plan under the Payer of Last Resort protocol. If you have other medical insurance for the above medical expenses, you have to file a claim with your other medical insurer to facilitate a reimbursement to your Raffles Shield Policy. Once we have received payment from your other medical insurer(s), we will credit the amount to your Raffles Shield Policy Year and Lifetime Limits.

SECTION 6: CLAIMANT'S DECLARATION ON BENEFICIAL OWNER (If applicable, please tick the box as appropriate)

I/We declare that:

☐ there is no beneficial owner under this Policy.

☐ there is/are beneficial owner(s) under this Policy.

Name	NRIC/FIN/Passport No.	Relationship with Policyholder

"Beneficial Owner" means the natural person who ultimately owns or controls the customer or the natural person on whose behalf business relations are established, and include any person who exercises ultimate effect control over a legal person or legal arrangement.

SECTION 7: DECLARATION & CONSENT

PERSONAL DATA NOTICE

1. I understand, acknowledge, agree and consent that Raffles Health Insurance Pte Ltd (**"RHI"**) or its representatives are permitted to :

   (a) collect, use, disclose and/or process my personal information set out in this form and any other personal information provided by me or from other sources such as employer, intermediaries, medical organisations, third party providers or agents (which may be sited outside of Singapore), other insurance companies (collectively the **"Personal Information"**) for the purpose(s) set out below; and/or

   (b) disclose and transfer such Personal Information to other sources such as other departments in RHI, employer, intermediaries, medical organisations, banks, CPF Board, reinsurers, third party service providers or agents (which may be sited outside of Singapore), other insurance companies, for the purpose(s) set out below :

   (c) **Purpose(s)**

   (i) processing, handling and/or dealing with my claims including the settlement of the claims and any necessary investigations relating to the claims;

   (ii) investigating the accident and/or my claims;

   (iii) carrying out and/or dealing with my instructions or responding to any enquiries by me;

   (iv) administering my claims (including the mailing of correspondence, statements, invoices, reports or notices to me, which could involve disclosure of certain personal data about me to bring about delivery of the same as well as on the external cover of envelopes / mail packages); and/or

   (v) complying with applicable law in administering, processing, handling and/or dealing with my claims.

2. I further acknowledge and consent that my Personal Information may be collected, used and/or disclosed by RHI for :

   (a) carrying out due diligence activities in accordance with legal or regulatory obligations or risk management procedures required by law or the Monetary Authority of Singapore (**"MAS"**) or implemented by RHI;

   (b) responding to requests for information from other insurance companies, MAS, General Insurance Association of Singapore (**"GIA"**), Life Insurance Association of Singapore (**"LIA"**) or other relevant government agency/authority (such as police).

DECLARATION & AUTHORISATION

1. I hereby declare that the information on this form and any documents attached to it is correct and complete and I have not withheld any information that could affect this claim.
2. I hereby authorise any hospital, physician or other person who has attended to me to furnish Raffles Health Insurance Pte Ltd or its representatives all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment, copies of all hospital or medical records.
3. I agree that a photocopy of this authorisation shall be considered as effective as the original.

X

_____

Signature

_____

Name of Policyholder

_____

NRIC / FIN /Passport No

Date:

X

_____

Signature

_____

Name of Insured

_____

NRIC / FIN /Passport No

Date:

Signature of Insured (If Insured is age 21 and above)

Attending Physician's Statement

(To be completed for patients seeking treatment at Overseas Hospitals / Private Hospitals / Clinics)

IMPORTANT NOTES: Please complete this form fully and accurately.

Name of Patient	Date of Birth	NRIC / Passport No	Gender ☐ Female ☐ Male

SECTION 1: Details of Illness / Injury

Final Diagnosis of illness or extent of injury ICD Code ☐☐☐

When did the patient first consult you for this condition?

Secondary Diagnosis ICD Code ☐☐☐

What was the patient's complaint or symptoms presented during the first consultation?

What was the cause of the illness / injury?

(If due to an accident, please furnish date of accident)

How long has the illness / symptoms been existing prior to consulting you?

Is the condition / treatment related to :	No	Yes	If '**Yes**', please elaborate:
a) Congenital Anomaly / Birth Defect / Genetic / Hereditary disorder?	☐	☐	
b) Dental / Gum Treatment / Oral Mucosal?	☐	☐	
c) Pregnancy / childbirth / abortion / miscarriage / birth control /infertility?	☐	☐	
d) Cosmetic / Aesthetic Treatment?	☐	☐	
e) Correction of eye refraction?	☐	☐	
f) Emotional / stress / psychiatric / psychological / sleep disorder?	☐	☐	
g) Attempted suicide / Self-inflicted Injury / Alcoholism / Drug Addiction?	☐	☐	
h) Natural / Physiological Menopause?	☐	☐	
i) Developmental Delay / Learning Disability	☐	☐	
j) STD, AIDS or infection by HIV?	☐	☐	
k) Human Papilloma Virus (HPV)?	☐	☐	
l) Has the patient been treated by other doctor (s)for this illness before consulting you? If Yes, please state the name of doctor, and name and address of clinic	☐	☐	
m) Was the patient referred by any of the above doctors?	☐	☐	
h) Did the patient suffer similar or related conditions in the past? If Yes, please state when, nature of problem, name and address of attending doctor and dates of treatment.	☐	☐	

SECTION 2: Details of Surgical Procedures & Treatment

Surgical operations performed on patient

Operation Codes*	Name of operation	Indication for operation	Tables*	Date performed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	----------	----------	_____	_____

Where was the operation / surgical procedure(s) performed? ☐ Hospital ☐ Clinic

Were the surgical procedures approached through the same incision? ☐ Yes ☐ No

Was there excision performed? ☐ Yes ☐ No

If yes, please provide the pathology report.

Name of Surgeon

_____

Name of Anesthetist

_____

If no surgery was performed, was the admission for diagnostic purpose?

Please provide the detailed discharge summary.

Is the patient still under your care for the condition?

☐ No. Please state date of termination _____

☐ Yes. How long do you expect to continue? _____

When are you going to review the patient again? _____

If patient has been referred to another doctor for follow-up, please furnish name and address of doctor.

Is the condition likely to relapse or require long term care? ☐ Yes ☐ No

* For surgery done in Singapore based on Tables of Surgical Operation for Medisave scheme, 1 Jan 2014.

SECTION 3: Doctor's Certification

Declaration

I …….. the undersigned, do hereby declare that I was the doctor in attendance during the last illness of ……and that the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from the Company.

Name of Doctor : _____ Signature : _____

Name of Clinic/Hospital : _____ Professional Qualification : _____

Clinic / Hospital Stamp : _____ Date : _____

A member of RafflesMedicalGroup

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