ntuc income

GROUP HOSPITAL & SURGICAL CLAIM FORM

Claim Procedures

1. Upon admission (if applicable), please sign the forms for CPF Medisave Deduction and Medisave-Approved Integrated Shield Plan* and pays a deposit as requested by the hospital.
2. Upon discharge from a hospital, please submit the following:
   (a) Duly completed claim form (Section 1). All items must be duly completed to avoid delay in the claim processing. Please indicate as 'N.A' if not applicable.
   (b) All original final hospital bills, doctor's bills and receipts.
   (c) For admission into Government/Restructured Hospital, please provide Inpatient Discharge Summary/Ambulatory Form/Pre Admission Form.
   (d) For admission into Private/Overseas Hospital, please provide Original Itemised/Detailed Hospital Bill and (Section 2) duly completed by attending doctor. If the attending doctor charge a fee for the completion of Section 2, it will be borne by the Insured Person.

* In the event your Medisave-Approved Integrated Shield Plan/CPF Medishield has made full/partial payment, your Group Hospital & Surgical Policy will be required to reimburse such a Plan in accordance with the CPF Act.

Important Notice

The acceptance of this form is NOT an admission of liability on the part of NTUC Income. Any documentary proof or medical report shall be furnished at the expense of the Policyholder or Insured Person. Please submit duly completed claim form with the supporting documents within one month of discharge from the hospital.

SECTION 1 – TO BE COMPLETED BY EMPLOYER & EMPLOYEE/DEPENDANT

COMPANY NAME: ______________________________ **POLICY NO.:** ____________________

PARTICULARS OF EMPLOYEE/DEPENDANT

PARTICULARS OF EMPLOYEE (as shown in NRIC/PP)			
Name (as shown in NRIC/PP)	NRIC/Passport No.	Date of Birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female
Occupation	Date of Employment	Email Address	Contact No.
Address			

PARTICULARS OF PATIENT (IF PATIENT IS DEPENDANT OF EMPLOYEE) (as shown in NRIC/PP/BC)			
Name (as shown in NRIC/PP/BC)	NRIC/Passport/BC No.	Date of Birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female
Relationship to Employee ☐ Spouse ☐ Child	Occupation		

MEDICAL CONDITION

1. DETAILS OF ILLNESS/ACCIDENT		
a. Illness/Sickness:	b. Describe Symptoms	c. Date the Symptoms Started
d. Name of Hospital/Clinic	e. Surgical Procedure	f. Period of Hospitalisation/Surgery
g. Name & Address of referring General Practitioner/Clinic	h. Name & Address of regular General Practitioner/Clinic	

GH/GHS/12/2010

2. PLEASE COMPLETE THE FOLLOWING IF YOU HAVE SUSTAINED INJURY AS A RESULT OF AN ACCIDENT

a. Date & Time of Accident	b. Place of Accident	c. Is it Work-related? ☐ Yes ☐ No

d. State HOW did the Injury/Accident happen. (Please enclose a copy of the police report, if any.)

e. Is the medical expenses claimable under your company's Work Injury Compensation Act Policy?

OTHER INFORMATION

3. Are you making/intending to make a claim from any insurer/other employer/any other parties for reimbursement of your medical bills? If 'Yes', please state the party that you are claiming from and submit a copy of the settlement letter/payment voucher. ☐ Yes ☐ No

Note: It is important to inform us if you are claiming from other insurance or any other parties for the same bill. You may be committing an offence if you claim or are reimbursed for more than the amount that you have incurred, regardless of the number of medical insurance policies you may have.

4. Benefits should be made payable to:
☐ Policyholder ☐ Employee

5. Payment to be made by:
☐ Cheque ☐ Giro - Employee's Bank ______________________

Branch ______________________

Account No. ______________________

DECLARATION AND AUTHORISATION

1. I hereby declare that the above statements are true and complete and I have not withheld any fact from NTUC Income.
2. I agree and authorise:
   (a) Any medical institution or medical practitioner, or insurer, or organization or person to release to NTUC Income any information as requested by NTUC Income; and
   (b) NTUC Income to release any relevant information concerning me/my child to any medical institution or medical practitioner, or insurer or organization or person.
3. I agree that a photocopy of this Authorisation is as valid as the original.

Name of Employee	Signature of Employee	Date (dd/mm/yyyy)
Name of Patient	Signature of Patient (To be signed by parent/legal guardian if the patient is below 21)	Date (dd/mm/yyyy)

TO BE COMPLETED BY EMPLOYER

Name of Employer	Effective Date of Patient's Insurance (dd/mm/yyyy)	Policy No./Plan Type

Name of Authorised Personnel	Signature & Company's Stamp	Date (dd/mm/yyyy)

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GROUP HOSPITAL & SURGICAL CLAIM FORM

SECTION 2 – TO BE COMPLETED BY THE ATTENDING DOCTOR (APPLICABLE FOR HOSPITALISATION or DAY SURGERY AT PRIVATE/OVERSEAS HOSPITALS or CLINICS)

Note: If the space provided is insufficient, please attach any written reports/diagnostic or lab-tests results.

1. Name of Patient (as shown in NRIC/PP/BC)	2. NRIC/Passport No. of Patient
3. Date Admitted (dd/mm/yyyy)	4. Date Discharged (dd/mm/yyyy)
5. Diagnosis(es) 1. 2. 3.	First Diagnosed Date (dd/mm/yyyy) 1. 2. 3.

NB: If there is more than one diagnosis, please advise if they are related or as a result of or are complications of the Primary Disorder (if applicable), please state and explain. Kindly indicate also, if the diagnosis is entirely unrelated.

6. When did patient first consult you for this condition? (dd/mm/yyyy)

7. Subsequent Consultation Dates (dd/mm/yyyy)

8. What were the complaints/symptoms presented?

9. How long has the patient been troubled by these symptoms prior to consulting you?

10. What were the underlying conditions? (Please number the dates according to the sequence in diagnosis(es) above.)	Diagnosis Date (dd/mm/yyyy)
1.	1.
2.	2.
3.	3.

11. Were any diagnostic/laboratory tests done? If 'Yes', please enclose a copy of the tests results.	☐ Yes ☐ No
12. Has the patient received any prior treatment for this condition before consulting you? If 'Yes', state when and give the name and address of doctor who treated the patient previously.	☐ Yes ☐ No
13. Was patient referred to you by a clinic/hospital? If 'Yes', state when was the referral and name and address of the referring doctor.	☐ Yes ☐ No
14. Did patient suffer similar or related conditions in the past? If 'Yes', please indicate nature of problem, name and address of Attending doctor and dates of treatment.	☐ Yes ☐ No
15. Has the patient ever suffered from any serious illnesses (e.g. Heart conditions, Kidney Failure, Stroke, Cancer etc) prior to this admission? If 'Yes', please provide us with the diagnosis, first date of diagnosis, and name and address of doctor seen.	☐ Yes ☐ No

16. Date/Type of operation/treatment performed. For surgery, please state surgical table and code. If no surgery was performed, please state treatment & medication given.	
17. Where 2 or more surgical procedures were performed, please specify whether they were done through the same incision.	
18. When was the patient FIRST advised to have the surgery? Name and address of the doctor who advised the patient to have the surgery.	
19. Was the treatment medically necessary? If 'No', please give details.	☐ Yes ☐ No
20. Was the condition/treatment related directly or indirectly to:	
a) Pregnancy, childbirth, elective abortion, birth control, infertility, reproductive assistance, impotence and their complications? If 'Yes', please give details.	☐ Yes ☐ No
b) Prevention of illness, promotion of health or enhancement of bodily function or appearance, cosmetic reason or refractive error of the eye? If 'Yes', please give details.	☐ Yes ☐ No
c) Congenital abnormalities or hereditary conditions or disorders? If 'Yes', please give details.	☐ Yes ☐ No
d) Developmental disorders? If 'Yes', please give details.	☐ Yes ☐ No
e) Self-inflicted injuries or injuries resulting from attempted suicide? If 'Yes', please give details.	☐ Yes ☐ No
f) Sexually transmitted diseases, AIDS, AIDS related complex or any conditions caused by or related to Human Immunodeficiency Virus (HIV)? If 'Yes', please give details.	☐ Yes ☐ No
g) Psychological or mental conditions? If 'Yes', please give details.	☐ Yes ☐ No
h) Drug addiction, Alcohol dependence or Gambling addiction? If 'Yes', please give details.	☐ Yes ☐ No
i) Dental treatment? If 'Yes', please give details.	☐ Yes ☐ No
j) An accident? If 'Yes', please give details of the accident and whether it is work-related and whether police report was made.	☐ Yes ☐ No
21. Has patient fully recovered from the condition(s)? If 'No', what are the follow-up treatments required?	

Name & Stamp of Attending Doctor

Signature of Attending Doctor

Date (dd/mm/yyyy)

Hospital/Clinic's Name and Address