

HOSPITAL & SURGICAL CLAIM FORM

NOTE : ALL QUESTIONS UNDER SECTION 6 HAVE TO BE COMPLETED BY CLAIMANT'S ATTENDING PHYSICIAN

1. PARTICULARS OF POLICYHOLDER

- (A) Policy No. :
- (B) Name of Policyholder :
(If group insurance, name of employer)
- (C) Name of Insured :
(Indicate if claimant is a spouse or child)

2. PARTICULARS OF CLAIMANT

- (A) Name :
- (B) NRIC/Birth Certificate/Passport No. :
- (C) Date of Birth :
- (D) Sex :

3. STATEMENT BY CLAIMANT

- (A) i. Nature of Sickness :
- ii. Date sickness first began :
- iii. Date first treated :
- iv. Name of hospital confined :
- v. Date admitted :
- vi. Date discharged :
- vii. Name and address of attending :
Physician/Surgeon (Please give name
of clinic if applicable)
- viii. Date surgery was performed (if any) :
- ix. Total amount of claim : \$

(B) i. If injury was as a result of an accident, : * Date :
 * Time :
 * Place :

ii. Circumstances of accident :

iii. Was the accident reported to the police? : [] Yes [] No
 If "Yes", which police station? Report number :
 if obtainable :

iv. Whom do you consider was responsible for : [] Self [] The other party
 the accident?

v. If other party, please specify name :

4. OTHER INFORMATION

(A) Are you covered for the whole or any part of the medical expenses resulting from the abovementioned illness or accident by:-

- i. Workmen's Compensation Insurance : [] Yes [] No
- ii. Any other medical benefits schemes/personal accident, life or other forms of insurance : [] Yes [] No

(B) If the answer to any of the above question is "Yes", please state full particulars:-

- i. Name and Address of Insurance Company :
- ii. Policy No. :
- iii. Expiry Date of Policy :
- iv. Other Information :

5. DECLARATION AND AUTHORISATION TO RELEASE INFORMATION

I, the undersigned, hereby declare that the particulars stated on this form are true in every respect and that I have supplied full information on all particulars relevant to this claim. I authorise any physician or other person who has attended to me to release any information acquired in the course of my examination or treatment to FIRST CAPITAL INSURANCE LIMITED.

Date : _____ Name of Witness _____

Identity Card No. _____

 SIGNATURE OF CLAIMANT
 (PARENT, IF A MINOR)

 SIGNATURE OF WITNESS

6. MEDICAL REPORT BY ATTENDING PHYSICIAN/SURGEON

- (A) Name of Patient :
- (B) i. Diagnosis of condition(s) :
- ii. What were the complaints or physical findings :
- iii. Was the condition related to employment? : [] Yes [] No
If "Yes", please give details.
- iv. Was the condition due to pregnancy, infertility or childbirth? : [] Yes [] No
If "Yes", please state date of commencement of pregnancy, or date of first treatment for Infertility. :
- v. Was the condition a congenital anomaly, nervous or mental disorder? : [] Yes [] No
If "Yes", please specify. :
- (C) i. When did the patient first consult you for this condition? :
- ii. How long had the patient been troubled by symptoms prior to consulting you? :
- iii. Has patient ever had the same or similar condition or symptoms relating thereto? : [] Yes [] No
If "Yes", please state when and describe
- iv. For how long has the above sickness or Injury existed? :
- (D) i. Name and nature of surgical or obstetrical procedure (if any) :
- ii. Date performed :
- iii. Place of operation performed : [] Hospital [] Clinic [] Others

Date _____

NAME AND SIGNATURE OF PHYSICIAN/
SURGEON

ADDRESS AND OFFICIAL STAMP

N.B.: The issue of this form is not an admission of liability by the Insurer.
The Insured must obtain at his own expense the above Medical Report from his Medical practitioner.