INDIA INTERNATIONAL INSURANCE PTE LTD
HOSPITALISATION INSURANCE CLAIM FORM

To avoid delay in settlement of the claim, the claimant must answer all questions applicable herein and attach bills which are reimbursable by the policy.

A) GENERAL

1) Name of Insured : _____

2) Policy Number : _____

B) DETAILS OF CLAIMANT

1) Name : _____ 2) Age : _____
3) NRIC No : _____ 4) Occupation : _____
5) Date Employed : _____ 6) Sex : _____

C) SICKNESS

1) Nature of Sickness : _____
2) Date First Began : _____
3) Date Admitted in Hospital : _____
4) Date Discharged from Hospital : _____
5) Has this condition been previously treated : _____
   If yes, give details : _____
6) Is this condition due to pregnancy or infertility : _____
   If yes, give details : _____
7) Is this condition arising from employment : _____
   If yes, give details : _____
8) Were you conveyed to the hospital by ambulance : _____

D) INJURY

1) Date and Time of Accident : _____
3) Circumstances and Place of Accident : _____
   _____
   _____
4) Describe nature of injuries sustained : _____
   _____
   _____
5) Is this, job related accident : _____
   If yes, give details : _____
   _____

6) Date Admitted : _____ 7) Date Discharged : _____

8) Were you conveyed to the hospital by ambulance : _____

E) HOSPITAL

1) Name of Hospital : _____

2) Address of Hospital : _____

3) Name and Address of Attending Physician/Surgeon : _____

F) OTHER INSURANCES

Is the claimant entitled to claim against Workmen's Compensation/other medical benefit insurance policies : _____

If yes, give details : _____

G) DETAILS OF HOSPITAL/SURGICAL EXPENSES INCURRED

(please enclose supporting bills)

	Details	Amount	Allowable Expenses for Office Use Not to be completed by claimant
a)	Hospital Room and Board (S$ _____ per day for ____ days)		
b)	Hospital Miscellaneous Services (I) Drugs and medicines consumes on premises (II) Dressings ordinary splint and plaster (III) Laboratory Examinations (IV) X-Ray Examinations (V) Electrocardiograms (IV) Physical Therapy (VII) Use of operating room (VIII) Anaesthesia and oxygen and their administration		
c)	Surgical Fees		
d)	In-Hospital Doctors visits :		
e)	Specialist Consultation :		
f)	Pre-hospitalisation : (I) X-Ray Examinations (II) Laboratory Examinations		

g)	Post-hospitalisation/Surgical treatment (Please furnish details)		
	C/F :		
	B/F :		
h)	Emergency Accident out-patient treatment		
I)	Ambulance Fee		
j)	Other expenses not covered above : (please furnish details)		
	TOTAL :		

H) CLAIM CHEQUE

Subject to liability being involved, amount payable under the policy should be made payable to :

[ ] Employee [ ] Claimant

[ ] Others (Please give details)

DECLARATION & MEDICAL INFORMATION AUTHORITY

I hereby authorised any hospital, surgeon, medical practitioner or clinic or other person who has attended to me or examined me for any reason, to disclose any and all informations with respect to any illness or injury and to provide copies of all hospital or medical records, including prior medical history. A photostat copy of this authorisation shall be considered as effective and valid as the original.

I hereby further affirm and declare that the answers to all the above questions are true in every respect.

Date

Signature of Claimant

STATEMENT BY THE INSURED

I/We hereby declare that to the best of our knowledge the insured person named above has been hospitalised for the duration stated in the claim form.

Signature of Insured