

Group Hospital & Surgical Claim Form

(Student Enrich Scheme)

Instructions:

Please furnish the following documents within one month from date of discharge from hospital:

For hospitalisation in Government / Restructured Hospital:

- (1) Duly completed and signed claim form (Part 1)
- (2) All original final hospital bills, doctor's bills and receipts
- (3) Inpatient Discharge Summary
- (4) Inpatient Admission Report (if available)
- (5) Day Surgery Admission Form (if available)

Please note we will reimburse up to \$75 for the medical report from Government / Restructured Hospital should we need the medical report to assess the claim.

For hospitalisation in Private Hospitals / Clinics / Hospitals outside Singapore

- (1) Duly completed and signed claim form (Part 1)
- (2) Medical Report by attending physician / surgeon (Part 2) – Medical report fee to be borne by claimant
- (3) All original final summary hospital bills, all original final itemised hospital bills, doctor's bills and receipts

Please submit the completed documents and mail them to the following address:

**Singapore Post Centre
P.O. Box 15
Singapore 914001
(Student Medical Claim)**

For claim enquires, please contact:

**Ms Genna Ang - Mobile no 96715922
Ms Christina Chng - Mobile no 97602569
Office No : 65178323**

Issued by HSBC Insurance (Singapore) Pte. Limited
 10 Eunos Road 8 #11-01 Singapore Post Centre Singapore 408600 Tel: (65) 6225 6111 Fax: (65) 6424 8036
 Web site: www.insurance.hsbc.com.sg
 Company registration no 195400150N

Part 1

A. Student's / Claimant's Details			
Name of Private Education Institution (PEI)		Policy Number	
Insured Member (Student)		NRIC / Passport Number	Date of Birth
Status Student	Course Start Date	Sex : M / F	Plan No.
Email Address	Contact Number (Home/Office) : _____ (Mobile No) : _____		
For Singapore Citizen/ Singapore Permanent Resident students or non-Student's Pass International students, please indicate if you have opt out of the medical insurance scheme arranged by your PEI. <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and address of regular / family doctor		
B. Claims Details			
Diagnosis		Symptoms experienced	
Date symptoms first started		Date FIRST consulted doctor or took drugs	
Name & address of doctor FIRST visited for this condition		Were you pregnant at the time of hospitalisation? (for female claimant) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the hospitalisation related to pregnancy, abortion, sterilisation, sub-fertility or infertility? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify condition and approximate date of commencement : _____		Had the illness been treated previously? <input type="checkbox"/> Yes <input type="checkbox"/> No 1. If yes, please provide the name and address of the attending physician 2. Dates of previous treatments	
Type of operation performed, if applicable			
Date of Admission	Date of Discharge	Name of Hospital / Clinic	Name and address of attending physician
Was the hospitalisation / day surgery due to an Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date / Time of Accident	Place of Accident
Describe how the accident happened		Describe the injuries	
C. Claims Payment Details			
Claim cheque to be made payable to: (please specify one only) <input type="checkbox"/> PEI <input type="checkbox"/> Student			
D. Declaration and Authorisation			
I hereby authorise any doctor(s), hospital(s) or dentist(s) or other person who have attended to me, to disclose to HSBC Insurance (Singapore) Pte. Limited any and all information with respect to my medical conditions(s) / treatment(s). I also hereby declare that the information stated in this form is true and correct.			
_____ PEI Administrator's signature / PEI's stamp / Date		_____ Student's / Claimant's signature / Date	

Part 2: MEDICAL REPORT

(To be completed by the Attending Physician / Surgeon)

Name of Patient		Policyholder (Employer)	
Policy Number	NRIC No / Passport No	Date of Birth	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female

1a) Final Diagnosis	ICD Code :
b) Secondary Diagnosis	ICD Code :
c) Is the condition due to i) Congenital anomaly / Genetic or Chromosomal disorder ii) Mental or Nervous or Psychiatric disorder iii) Treatment of teeth or gum tissue or oral cavity iv) Self-inflicted injury / drug addiction / alcoholism v) Job related injury vi) Sexually transmitted disease, AIDS and illness or disease related to HIV vii) Cosmetic purpose viii) Pregnancy, childbirth, miscarriage, abortion, impotency, sterilisation, sub-fertility or infertility. If for miscarriage, was it due to accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
d) Is the surgery medically necessary?	<input type="checkbox"/> Yes <input type="checkbox"/> No

2a) When did the patient first consulted you for the above condition / injury?	b) What was the complaint(s) when patient first see you?
c) How long had the patient been troubled by the symptoms prior to consulting you?	d) How long had this condition / injury been existed prior to consulting you?
e) Had the patient ever had same or similar condition / injury / symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not to my knowledge If yes, when was the patient last treated for the condition / injury / symptoms?	f) Please specify the approximate date of discovery of the condition / injury.

3a) Was the hospitalisation / day surgery due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide the following information:	
b) Date & Time of accident	c) Place of accident
d) Describe how the accident happen	e) Describe the injuries

4a) Was the patient being referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please the details below:		
Name of referring doctor	Date of treatments	Name of Hospital / Clinic & Address

5a) Period of Hospitalisation:		b) Surgical Procedure Performed (if applicable):					
Admission Date	Discharge Date	Surgical Procedure	Operation Code				Operation Table
Admission Date	Discharge Date	Surgical Procedure	Operation Code				Operation Table

c) Where was the surgical procedure carried out? <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic	d) Name of surgeon(s)
e) If more than one surgical procedure had been performed, were they done through the same incision? <input type="checkbox"/> Yes <input type="checkbox"/> No	f) If excision has been done, please indicate the size(s) / measurement(s) of the lesion(s) / tumour(s): (please attach a copy of the histology report)
Please tick the illness classification for the condition: <input type="checkbox"/> Alimentary system <input type="checkbox"/> Autoimmune disorder <input type="checkbox"/> Cancer/Malignant tumour growth <input type="checkbox"/> Cardiovascular system <input type="checkbox"/> Dental <input type="checkbox"/> Ear, Nose & Throat system <input type="checkbox"/> Eye <input type="checkbox"/> Genito-urinary system <input type="checkbox"/> Gynaecological / Obstetric <input type="checkbox"/> Haematological disorder <input type="checkbox"/> Infectious disease <input type="checkbox"/> Metabolic & endocrine disease <input type="checkbox"/> Musculo-skeletal system <input type="checkbox"/> Nervous system <input type="checkbox"/> Psychological / Psychiatric <input type="checkbox"/> Respiratory system <input type="checkbox"/> Skin and subcutaneous tissue	

6a) Is the patient still under your care for the condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	b) If patient had been referred to another doctor for follow up, please furnish the name and address of the doctor.
If yes, how long do you expect this to continue and when is the next review date?	
If no, please state date of termination	
c) Is the condition likely to relapse or require long term care? <input type="checkbox"/> Yes <input type="checkbox"/> No	

_____ Signature of Physician / Surgeon / Date	_____ Stamp of Clinic / Hospital
_____ Name / Designation	