



Liberty Pte Limited
One Raffles Quay #40-01 North Tower
Singapore 048583
Tel: 1800-LIBERTY (5423 789)
UEN | GST Reg. No. 201538069C
libertyinternational.com/sg

Claim Form - Medical

Please complete all sections to facilitate the processing of your application. This form is issued without admission of liability and it must be completed and returned to us immediately, whether or not a claim is made. Any documentary proof or report required by liberty shall be furnished at the expense of Policyholder or Claimant. Please submit the completed and signed claim form together with supporting documents to: Claims_admin.sg@libertymutual.com.

Information of Policyholder

Name of Policyholder:	Policy No.:
_____	_____
Is Policyholder GST – registered?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, is Policyholder allowed to claim the <u>GST</u> on the Insurance <u>Premium</u> paid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email:	_____

Information of Claimant

Name of Claimant:	Policy No.:	
_____	_____	
Mailing Address:	Postal Code ()	
_____	_____	
NRIC/FIN/Passport No.:	Date of Birth:	Contact No.:
_____	_____	_____
Occupation:	Date Employed:	Gender:
_____	_____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Email:	_____	
Is the condition/disability suffered due to:	<input type="checkbox"/> Illness	<input type="checkbox"/> Accident
If the condition/disability suffered is due to illness, please provide the following:		
i. Diagnosis:	_____	
ii. Date of symptoms started:	_____	
iii. Details of all symptoms and nature of medical condition/disability suffered:	_____	
Detailed description of injuries/disability suffered:	_____	



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Information of Claimant

If disability is due to accident, please provide detailed description of accident
(Please enclose a copy of the police report if any): _____

Did you seek medical treatment prior to being diagnosed with the illness for which you are now claiming? Yes No

If Yes, please state:

Name of Physician: _____

Mailing Address: _____

Postal Code ()

Are you claiming from any other insurer in respect of this illness/injury? Yes No
If Yes, please state:

Name of Insurance Company: _____

Policy No.: _____

Details of Accident

Date of Accident: _____

Time of Accident: _____

Place of Accident: _____

How did the accident happen?

Road-related Yes No

Work-related Yes No

Others Yes No

Describe the Nature of Injuries sustained: _____



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Payment Details

Please select the claim payment mode.

- For payment by direct transfer into Policyholder's bank account.
Please provide a copy of your bank account statement showing the Name of Bank, Name of Account Holder and Account Number for your initial claim submission.

Full Name (as shown in the bank account): _____	Nationality: _____
Name of Bank: _____	Bank Account Number: _____

- For payment by PayNow
Please provide us with a copy of NRIC for verification purpose. The claim reimbursement can only be made to the Insured/Claimant and will be paid via transfer to your bank account linked by PayNow NRIC/FIN ID by default. Please ensure that you have signed up for PayNow with your bank by linking it to your NRIC/FIN ID.

NRIC/FIN ID: _____	UEN: _____
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INDEMNITY

The Company shall not be liable for any loss incurred by you as a result of you providing the Company with incorrect bank account details for the payment of your claim.

PERSONAL DATA PROTECTION

By signing this form, I/we consent to Liberty Pte Limited ("Liberty") and its authorised service providers, related entities, and partners (collectively, "Appointees") collecting, using, and disclosing my/our personal data, and any personal data of other individuals provided by me/us, for purposes including: assessing and providing insurance products and services; policy administration, renewals, claims, and payments; compliance, audit, and regulatory reporting; research, analytics, and service improvement; and communication and customer support. I/we confirm that I/we have read and agree to Liberty's Data Protection Policy at <https://www.libertyinternational.com/sg/footer/privacy-policy>, which explains how Liberty manages personal data, including cross-border transfers. If I/we provide personal data of other individuals, I/we warrant that I/we have obtained their consent (or consent from their legal representatives, where applicable) for these purposes. I/we understand that I/we may access, correct, or withdraw consent for my/our personal data at any time by contacting Liberty's Data Protection Officer at privacy.officer.ap@libertyglobalgroup.com, subject to legal and contractual obligations.



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DECLARATION

- 1) I declare that I have complied with the conditions and warranties (if any) of the Policy and in no manner deliberately caused the said loss or damage or exaggerated the claim or sought unjustly to benefit by any fraud or willful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.
- 2) I authorise the release of any medical information necessary to process this claim.

Date

Signature of Claimant

Date

Signature of Policyholder & Company Stamp



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Medical Information (to be completed by the attending physician)

Name of Patient: _____		NRIC/FIN/Passport No: _____	
Date when the patient first consulted you: _____	Prior to the first consultation with you, when did the patient first suffer the symptoms of the condition: _____		
Presenting complaints: _____			
Was the Patient referred by another physician?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, please provide details:			
Name of Physician & Clinic: _____		Contact No.: _____	
Mailing Address: _____			
		Postal Code	()
State your diagnosis of the illness/injuries: _____			
Details of Surgical Operation(s)/Procedure(s) done: _____			
Date of Admission: _____		Date of Discharge: _____	
Was there any surgery carried out for this condition?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, please provide details:			
Surgical Operation or Procedure	Date of Operation or Procedure	Surgical ICD Code (For doctor to complete)	
Is there any connection between the present condition and any other pre-existing illness or previous accident?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, please provide details: _____			
Is the Condition of the Patient:			
Attempted Suicide	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Drug/Alcohol related	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Genetic or chromosomal disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hereditary or Congenital in nature	<input type="checkbox"/> Yes	<input type="checkbox"/> No	



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Infertility related	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnancy related	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychological/Mental Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Related to cosmetic treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Self-inflicted injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexually transmitted disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If any of the above is Yes, please provide details: _____		

Medical Information (to be completed by the attending physician)

Is the Condition of the Patient related to an Accident? If Yes, please provide details of the Accident, whether it is work-related and if police report was made? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will illness/injury require further follow-up treatment If Yes, please provide details: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other relevant information: _____		

Please furnish copies of all the reports/investigations results.



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I declare that I have in no manner deliberately exaggerated the claim or sought unjustly to benefit by any fraud or willful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.

I authorise the release of any medical information necessary to process this claim

Date

Signature of Physician

Name of Physician:

Contact No.:

Company Stamp:

