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 – Foreign Worker (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?	Please select
If yes, is Policyholder allowed to claim GST on the insurance premium paid?	Please select
Email: _____	Contact No.: _____
Plan No.: _____	

Information of Claimant

Name of Claimant: _____		Occupation: _____
NRIC/FIN No.: _____	Date of Birth: _____	Work Permit/Pass No.: _____
Nationality: _____	Date Employed: _____	Gender: Please select
Is the condition/disability suffered due to:		Please select
If the condition/disability suffered is due to illness, please provide the following: a) Diagnosis: _____		
b) Date of symptoms started: _____	c) Details of all symptoms and nature of medical condition/disability suffered: _____	

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

Are you claiming from any other insurer in respect of this illness/injury? If yes, please state:	Please select
Name of Insurance Company: _____	Policy No.: _____
Have you been hospitalised or submitted claims for any illness/injury for the past three years? If yes, please provide details of the date and description of the illness/injury.	Please select

Date	Description of illness/injury

Details of Accident

How did the accident happen? _____	Work-related: Please select
Describe the nature of injuries sustained: _____	

Date of Accident/Loss/Injury: _____	Time of Accident/Loss/Injury: _____	Place of Accident/Loss/Injury: _____

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Payment Details

Please select the claim payment mode.

☐ For payment by direct transfer into Policyholder's bank account.
☐ For payment by direct transfer into bank account under someone other than Policyholder.
A Letter of Authorization and/or proof of relationship is required, together with a copy of the payee's identification document (NRIC or passport) and bank statement.

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: _____

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.

DECLARATION

a) 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.
b) I authorise the release of any medical information necessary to process this claim.
c) 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 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@libertymutual.com, subject to legal and contractual obligations.

_____ _____
Date Signature of Claimant

_____ _____
Date Signature of Policyholder
(Company stamp, if applicable)

Claim Form – Foreign Worker (Medical)

Medical Information (to be completed by attending physician)

Name of Patient: _____	NRIC/FIN 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? If yes, please state:	Please select
Name of Physician: _____	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: _____
Is there any connection between the present condition and any other pre-existing illness or previous accident? If yes, please provide details: _____	Please select
Is the Condition of the Patient: Hereditary or Congenital in nature	Please select
Psychological/Mental Condition	Please select
Self-inflicted injury	Please select

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Attempted suicide	Please select
Sexually transmitted disease	Please select
Related to cosmetic treatment	Please select
Infertility related	Please select
Pregnancy related	Please select
Drug/Alcohol related	Please select
If any of the above is Yes, please provide details: _____	
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? _____	Please select
Will illness/injury require further follow-up treatment? If yes, please provide details: _____	Please select
Any other relevant information: _____	

Please furnish copies of all the reports/investigations results.

I hereby certify that I have personally examined and treated the Patient for the above illness/injuries and that the facts as given above present my opinion of the Patient's condition.

_____
Date

_____
Signature of Physician

Name:

Contact No.:

Company Stamp: