eTiQa Insurance

HOSPITALIZATION INSURANCE CLAIM

This form is issued without admission of liability and must be completed and returned after completion of treatment. No claim can be considered unless the Medical Certificate overleaf is completed at the policyholder's expense.

1. POLICYHOLDER _____ POLICY NO. _____

   ADDRESS _____ TEL: OFFICE _____

   _____ RESIDENCE _____

2. PERSON UNDER TREATMENT _____

   BUSINESS / OCCUPATION _____ DATE OF BIRTH _____

3. (a) Nature of illness / injury (b) When did it commence ?	
4. Name and address of the Doctor whom she / he first consulted	
5. Name and address of her / his usual Doctor	
6. Has she / he ever suffered before from the illness / injury in respect of which you are claiming ?	
7. Have you previously claimed or received compensation under an Accident or Hospitalisation Policy ? If so, give particulars	
8. (a) Are you insured elsewhere ? (b) If so, give the names of Comapny / Insurer and amounts you are entitled to claim	

I claim the amount of $ _____ being expenses incurred by me for treatment in accordance with the particulars above and receipted bills attached.

I / We hereby declare that the foregoing particulars are true and correct, that no information has been withheld and that the amount claimed is an accurate assessment of the loss suffered.

_____ _____

Date Signature of Policyholder

The questions overleaf must be answered by a registered Medical Practitioner.

ATTENDING PHYSICIAN's MEDICAL REPORT

Note : I) The Insured Person / Claimant must obtain at his/her own expense the Medical Report from Attending Physician / Surgeon
II) This report must be completed by the Attending Physician / Surgeon whose replies should be as full as possible

1. Name of Patient :

2. Admission Period :

3. Final Diagnosis (Based on ICD, 1975 Revision, WHO) of illness or extent of injury

4. What is the cause of the illness / injury ?

5. Please specify the approximate date of discovery of the illness / injury:

6. How long has the illness / injury been existing prior to consulting you ?

7. When did the patient first consult you for this condition ?

8. Did the patient has any symptoms prior to consulting you ? ☐ Yes ☐ No ☐ Not to my knowledge

If YES, please indicate the nature of symptoms and date the symptoms first started:

Doctor(s) previously consulted by the patient for the above condition:

	Name	Date	Name of Clinic / Hospital	Address
1)				
2)				

9. Describe the surgical procedures / treatment rendered. If no surgery was performed, please state the treatment / medication given.

Date of surgical procedures / treatment rendered: _____

10. Is the patient still under your care for this condition ? ☐ Yes ☐ No

If NO, please give the date service was terminated, and furnish name and address of doctor if the patient has been referred to another doctor for follow-up:

11. What is the prognosis of this illness ?

12. Is this treatment related to the following :

(a) Pregnancy or Childbirth ?	☐ Yes	☐ No
(b) Abortion or miscarriage ?	☐ Yes	☐ No
(c) Infertility or sub-fertility condition ?	☐ Yes	☐ No
(d) Sexually transmitted disease ?	☐ Yes	☐ No
(e) Congenital anomaly; a physical defect at birth; a genetic condition ?	☐ Yes	☐ No
(f) Refractive error of the eye ?	☐ Yes	☐ No
(g) Dental surgery / treatment ?	☐ Yes	☐ No
(h) Mental or nervous disorder ?	☐ Yes	☐ No
(i) Self inflicted injury ?	☐ Yes	☐ No
(j) Cosmetic Surgery ?	☐ Yes	☐ No

13. (a) Is this condition related to any accident or injury ? ☐ Yes ☐ No

(b) If this a work related illness or accident ? ☐ Yes ☐ No

If YES to any of the above (a) or (b), please provide the date of the accident and explain the extent of the injury sustained.

I hereby certify that the above patient had been examined and treated by me for the above * injuries / illness and the statement given above present my opinion of his / her condition.

_____ _____

Signature of Physician / Surgeon Date

_____ _____

Name / Designation Name and Address of Clinic / Hospital

* to delete as applicable

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