



FEDERAL INSURANCE COMPANY

One of the Chubb Group of Insurance Companies

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 Unique Entity No. S83FC3361G

STANDARD PERSONAL ACCIDENT & MEDICAL EXPENSES CLAIM FORM[®]

The Insured is requested to state as fully and as accurately as possible the information asked for hereunder in order to expedite claim processing and to return the form immediately to the Company. Any documentary proof or reports required by the Company shall be furnished at the expense of the Policyholder or Claimant. Acceptance of this Form is not in itself and admission of liability on the part of the Company.

A. POLICYHOLDER / CLAIMANT

1. Policyholder _____ Policy No. _____
2. Address _____
3. Tel / Mobile _____ Email _____
4. Employee/Claimant _____ Age _____ Sex F M
5. NRIC / Passport No. _____ Marital Status _____
6. Occupation _____ No. of Children / Ages _____ / _____
7. Commencement date of employment _____ Tel / Mobile _____

If employed less than 12 months, state name of prior medical insurer, if any/known: _____

8. Country of Posting (if applicable) _____ Home Country _____ Date of Posting _____
9. Insured Person (if not Employee/Claimant) _____ NRIC/ Passport No. _____ Age _____ Relationship to Employee _____

10. Insured Person's prior medical insurer, if insured less than 12 months under this policy _____

11. Are there any other insurance which would cover this loss? Yes No If yes, tick box if claim was submitted to them.
 Name of Insurance Company & Policy No. _____

B. DETAILS OF INCIDENT

1. Date and Time: _____ 2. Place: _____

3. If claiming Medical Expenses, please state diagnosis and/or reason for consultation or medical treatment. _____

4. Describe nature and cause of injury or sickness (or death):

5. Have you ever suffered this or a similar condition or was this recurrence of a previous illness or injury? Yes No

If yes, please provide details, including dates: _____

MEDICAL CERTIFICATION OF TREATMENT

This certificate is to be completed in full by a duly qualified and registered medical practitioner at the expense of claimant.
 Questions 19 and 20 are relevant only if claim is made for Permanent Disablement and Temporary Total/Partial Disablement Benefits covered under the Policy.
Please give a definite answer to each question. Dashes are not sufficient.

1. Name of Patient:	2. Final diagnosis of illness or extent of injury. What are the complaints or physical findings?
3. What was the cause(s) of illness / injury?	
4. Is condition due to pregnancy, infertility or childbirth? Yes <input type="checkbox"/> No <input type="checkbox"/>	5. Is condition a congenital anomaly or a physical defect present at birth? Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Is condition a mental or nervous disorder? Yes <input type="checkbox"/> No <input type="checkbox"/>	7. Was condition due to self-inflicted injury or sexually transmitted disease? Yes <input type="checkbox"/> No <input type="checkbox"/>
8. When did the patient first consult you for this condition? Date:	9. Did patient have any symptoms prior to consulting you? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please state date symptoms first started:
10. Please specify the approximate date of discovery of the illness or injury. Date:	11. If this condition existed before symptoms became apparent to the patient, please state when in your view this condition began to develop. Date:
12. Has patient ever had same or similar condition? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please state when and describe. <u>Date(s)</u> <u>Description</u>	13. Has patient ever consulted any other doctors for the same or similar condition? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please state: <u>Date(s)</u> <u>Names and Addresses of other doctors</u>
14. Was the patient referred by any doctor to see you? Yes <input type="checkbox"/> No <input type="checkbox"/>	15. Please state the name and address of the referring doctor.
16. Please describe the surgical procedures or treatment rendered. Date the surgical procedures or treatment was rendered:	17. Was surgery / treatment done for cosmetic reasons? Yes <input type="checkbox"/> No <input type="checkbox"/>
	18. Is this an elective surgery / treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>
19. How long has the patient been totally or partially disabled from engaging in or attending to usual business as the result solely of the injury? How much longer do you consider such disablement will continue?	Totally from _____ To _____ Partially from _____ To _____ Totally from _____ To _____ Partially from _____ To _____
20. Is patient fit for work? If yes, please state date:	Yes <input type="checkbox"/> Date _____ No <input type="checkbox"/>

I certify that I have satisfied myself by personal examination of the Patient and the foregoing statements are correct to the best of my knowledge and belief. Should the insurance company requires further medical information in connection with the above, I would release the said information upon the sanction of the Patient.

Signature of Physician / Surgeon: _____

Date: _____

Name and Title (with Official Stamp): _____

Name and Address of clinic / hospital: _____