

# Hospital Income Plan

## Claim Form



\*SG020\*



### Important Information

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This claim form is to facilitate your claim in the event of you or a member of your family is being confined to hospital while being insured under a Hospital Income policy.

You can help to avoid unnecessary delay in processing your claim by ensuring that:

1) Sections A to E are fully completed and signed by the Insured and/or Claimant.

2) Section F is completed by the Claimant's Attending Physician. Please note that you or the Claimant is responsible for any expenses incurred in obtaining medical evidence in support of the claim.

3) If you are claiming for Recuperation/Post-Hospitalisation benefits, please attach detailed Pre-Medical/Final Hospitalisation/Post-Medical Report or a copy of the Inpatient Discharge Summary to the Claim Form.

4) If you are claiming for Medical/Hospital expenses, please attach detailed copies of your Final Bills and Receipts.

The issue and acceptance of this form does NOT constitute an admission of liability by Chubb Insurance Singapore Limited (Chubb) or waiver of its rights.

## Section A: Particulars of Policyholder/Insured Person

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Name of Policyholder/Insured Person (as shown in NRIC/Passport):

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Address of Policyholder/Insured Person:

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Postal Code: 

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Policy No (s):

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Period of Insurance: From: DD / MM / YYYY

To: DD / MM / YYYY

NRIC/Passport No.: 

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Date of Birth: DD / MM / YYYY

Nationality: 

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Age: 

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Tel No. (Mobile): 

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Gender: ☐ Male ☐ Female

Tel No. (Residence): 

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Tel No. (Office): 

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Email: 

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Name of Intermediary (if any): 

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Name of Employer: 

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Occupation: 

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Date of Employment: DD / MM / YYYY

Name of Claimant (as shown in NRIC / Passport) - if different from Insured Person:

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Address of Claimant:

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Postal Code: 

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NRIC/Passport No.: 

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Date of Birth: DD / MM / YYYY

Nationality: 

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Age: 

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Tel No. (Mobile): 

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Gender: ☐ Male ☐ Female

Tel No. (Residence): 

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Tel No. (Office): 

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Email: 

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Relationship to Insured: 

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Name of Employer: 

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Occupation: 

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Date of Employment: DD / MM / YYYY

## Section B: Payment Details

Please provide details for payment of your claim in the event that the claim is deemed payable by Chubb.

I hereby authorise and request Chubb to pay benefit due in respect of this claim as follows (Name as per Identification Card and/or Bank Account):

☐ **Electronic Funds Transfer** - For payments in SGD and to bank accounts in Singapore (Recommended)

Payee Name (As per bank account name): \_\_\_\_\_

Name of Bank: \_\_\_\_\_

Branch Code No.: \_\_\_\_\_ Account No.: \_\_\_\_\_

Note: For a more seamless experience, we recommend selecting the Electronic Funds Transfer (EFT) option so you can receive the remittance within 3-5 days upon approval of claim.

☐ **Cheque Payment**

Payee Name (as per bank account name): \_\_\_\_\_

Note: If no name is provided, settlement will be effected to the payee as provided for under the terms of the policy.

### Important Notice:

Chubb shall (i) be discharged from all liability under this claim and (ii) not be liable for any and all losses incurred by you, as a result of you providing Chubb with an incorrect bank account number under this section for the payment of this claim.

## Section C: Details of Claim

Name of Hospital: \_\_\_\_\_

Period of Hospitalisation: From: DD / MM / YYYY To: DD / MM / YYYY

Was the Insured referred by a General Practitioner/Specialist/Other Hospital?

☐ Yes ☐ No

If **Yes**, please provide details below:

Name of General Practitioner/Specialist/Hospital

\_\_\_\_\_

Address:

\_\_\_\_\_

\_\_\_\_\_ Postal Code: \_\_\_\_\_

Please complete this portion if hospitalisation was due to accident

Date of the Accident: DD / MM / YYYY

Time of the Accident (24-Hour): HH : MM

Country of Accident: \_\_\_\_\_

Place of Accident: \_\_\_\_\_

When and Who discovered the Accident: \_\_\_\_\_

Relationship of person to the Insured: \_\_\_\_\_

Were there witnesses to the accident?

☐ Yes ☐ No

If **Yes**, please provide details below:

	Witness 1	Witness 2
Name:		
Address:		
NRIC:		
Contact Number:		

Was the Insured under the influence of alcohol, medication, drugs or any other intoxicating substance at the time of accident? ☐Yes ☐No  
If **Yes**, please provide details below (Please use supplementary sheet if necessary):

Name/Type of Alcohol, Medication, Drugs or Intoxicating Substances	Quantity Consumed	Date And Time Consumed

Nature of Injury (e.g. fracture, cut, bruises, etc): \_\_\_\_\_

Chronology and Description of the Accident (Please use supplementary sheet if necessary).

\_\_\_\_\_  
\_\_\_\_\_

Please complete this portion if hospitalisation was due to an illness

**Details of the Medical Practitioner who is currently treating the Insured**

Name of Clinic / Hospital: \_\_\_\_\_ Name of Doctor: \_\_\_\_\_

Address:

\_\_\_\_\_  
\_\_\_\_\_ Postal Code: \_\_\_\_\_

Tel/Email: \_\_\_\_\_

Nature of Illness (describe the symptoms suffered).

\_\_\_\_\_  
\_\_\_\_\_

Date of Symptoms First Noticed: DD / MM / YYYY

Date of First Consultation with a Medical Practitioner for this Condition: DD / MM / YYYY

Describe the symptoms presented during the first consultation.

\_\_\_\_\_  
\_\_\_\_\_

Has the Insured ever seen a doctor for any similar condition in the past? ☐Yes ☐No

If **Yes**, please provide details of the Clinic/Hospital.

Name of Clinic/Hospital: \_\_\_\_\_ Name of Doctor: \_\_\_\_\_

Address:

\_\_\_\_\_  
\_\_\_\_\_ Postal Code: \_\_\_\_\_

Tel/Email: \_\_\_\_\_

## Section D: Any Other Claims/Insurance

Have you claimed or are there any other insurance policies that cover or may provide cover for hospitalisation, whether for this incident or in the past? If **Yes**, state:

Name of Insurance Company	Policy No.	Type of Policy	Date Policy Effected

Are you claiming from any other insurance company or other sources in respect of injury or illness? If **Yes**, state:

Name of Insurance Company	Policy No.	Amount of Benefits	Date Policy Effected

## Section E: Declaration

Did you remember to enclose the following? (Where applicable)

Document	Yes	N/A
Traffic Police Report (if involved in Road Accident)	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Final Hospital Bill	<input type="checkbox"/>	<input type="checkbox"/>
Written notes from Physician on type of injury sustained/Inpatient Discharge Summary or Medical Report	<input type="checkbox"/>	<input type="checkbox"/>

By signing this form, I/We agree that Chubb will use the information supplied here and during the formation and performance of this policy, for policy administration, customer services, claims handling and fraud analysis and prevention, and that Chubb may disclose such information to its service providers, agents, authorities and other parties for these purposes.

I/We hereby authorise any hospital, physician, and any other person or entity who has attended to or examined the Insured, to furnish to Chubb or its authorised representatives, any and all information with respect to any illness or injury or loss, medical history, consultation, prescriptions or treatment, copies of all hospital, medical or other records, investigation status and results, and such personal information as Chubb in its absolute discretion considers relevant for its assessment of this claim. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

I/We do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I/We agree that if I/We have made or in any further declaration or representation shall make any false or fraudulent statements or suppress, conceal or falsely state any fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past, present or future claims shall be forfeited.

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Signature of Insured Person  
(if different from Claimant)

\_\_\_\_\_  
Date (DD/MM/YYYY)

### Note

Kindly submit the completed claim form via email to [A&H.Claims.Singapore@chubb.com](mailto:A&H.Claims.Singapore@chubb.com). Please ensure that the relevant supporting documents are submitted as well.

### Contact Us

Please visit our website at [www.chubb.com/sg](http://www.chubb.com/sg) or contact us at +65 6398 8000.

**Section F: Attending Physician's Statement (To be completed by attending physician)**

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Name of Patient: \_\_\_\_\_

NRIC/Passport No.: \_\_\_\_\_ Gender ☐ Male ☐ Female Date of Birth DD / MM / YYYYIf Injury, when did Accident occur? DD / MM / YYYY If Sickness, when did symptoms first occur? DD / MM / YYYY

Describe the Accident:

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State the Nature of Injury or Sickness (Describe the complications - if any).

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Final Diagnosis: \_\_\_\_\_ When was the Patient first informed of this diagnosis? DD / MM / YYYY

If there is more than one diagnosis, please advise whether they are directly or indirectly related to each other (Please provide details).

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When did the Patient first received medical attention for this condition? DD / MM / YYYY

By who and where? (Please provide details below)

Name of Clinic/Hospital \_\_\_\_\_

Address \_\_\_\_\_

Name of Doctor \_\_\_\_\_

Has the Patient ever had this or any similar condition? ☐ Yes (Please provide details below) ☐ No

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What was the underlying cause(s) of the diagnosed condition(s)? Please include the date of diagnosis and symptoms first occurred for the underlying cause(s).

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Did the Patient receive any treatment for the condition(s) prior to consulting you? ☐ Yes ☐ No

Nature of Surgery (if any): \_\_\_\_\_ Surgical Code: \_\_\_\_\_

If 2 or more surgical procedures were performed, were they performed through a single incision? ☐ Yes ☐ No

Is the present condition due to:

congenital anomaly? ☐ Yes ☐ No (Please specify) \_\_\_\_\_nervous or mental disorder? ☐ Yes ☐ No (Please specify) \_\_\_\_\_pregnancy/childbirth/infertility? ☐ Yes ☐ No (Please specify) \_\_\_\_\_alcohol influence/drug abuse/self-inflicted injury? ☐ Yes ☐ No (Please specify) \_\_\_\_\_

HIV/AIDS/AIDS Related complications (ARC)? ☐ Yes ☐ No (Please specify) \_\_\_\_\_  
Venereal Disease? ☐ Yes ☐ No (Please specify) \_\_\_\_\_  
Cosmetic surgery/weight reduction? ☐ Yes ☐ No (Please specify) \_\_\_\_\_

Were the condition(s) or treatment directly or indirectly related to each other? (Please provide details)

Name of Hospital admitted: \_\_\_\_\_

Address of Hospital admitted: \_\_\_\_\_

Period of Hospitalisation: From: DD / MM / YYYY To: DD / MM / YYYY

Are you the Patient's usual doctor? ☐ Yes ☐ No

If **No**, please provide details of the usual doctor.

Name of Doctor: \_\_\_\_\_ Tel/Email: \_\_\_\_\_

Address of Doctor:

Has the Patient fully recovered from the condition(s)? ☐ Yes ☐ No

If **No**, please provide details of the follow-up treatment(s) required.

I hereby certify that I have personally examined and treated the patient for the above injury/sickness and that the facts as given above present my opinion of his/her condition.

\_\_\_\_\_  
Name of Physician

\_\_\_\_\_  
Qualification / Field of Expertise

\_\_\_\_\_  
Official Address

\_\_\_\_\_  
Tel/Email

\_\_\_\_\_  
Signature with Official Stamp

\_\_\_\_\_  
Date (DD/MM/YYYY)

Please click to submit your claim form

**Submit**

**Chubb. Insured.™**