The Overseas Assurance Corporation Limited (Reg. No. 1920 00003W)
(a wholly-owned subsidiary of Great Eastern Holdings Limited)
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HEALTH CLAIM FORM

Please state as fully and accurately as possible the information asked for below and to return this form immediately to the Corporation with original final bills/receipts. The acceptance of this form is not in itself an admission of liability on the part of the Corporation.

SECTION A – INSURED'S DETAILS

Name of Insured	NRIC/Passport No.	Policy No.
Address	Sex: Male / Female	Contact No.

SECTION B – CLAIMANT'S DETAILS

Name of Claimant		NRIC/Passport No.	Date of Birth
Sex: Male / Female	Occupation	Industry of Business	Relationship to Insured

SECTION C – CLAIM DETAILS

Question	Answer
1. PLEASE COMPLETE IF HOSPITALISATION WAS DUE TO ACCIDENT:	
(a) Date and Time of Accident.	(a) Date: __________________ (D/M/Y) Time: ____________________
(b) Nature of Accident (*Describe in details, how & where it happened*).	(b)
(c) Describe in details the injuries sustained, indicating the part of the body injured and the type of injury (*eg. fracture, cut, bruise, etc*).	(c)
2. PLEASE COMPLETE IF HOSPITALISATION WAS DUE TO SICKNESS:	
(a) Nature of Sickness (*describe the symptoms suffered*).	(a)
(b) Date of when symptoms were first noticed.	(b)
(c) Date of first consultation with a medical practitioner for this condition.	(c)
(d) Has the claimant ever seen a doctor for any similar condition in the past?	(d) ☐ No ☐ Yes, Name of Doctor: ________________________ Address of Doctor/Hospital: ____________________ ____
3. (a) Name of Hospital	(a)
(b) Period of Hospitalisation	(b) Date Admitted: ________________ Date Discharged: ______________
4. If Claimant was hospitalised outside Singapore, please give the following information:	
(a) Name of Hospital.	(a)
(b) Purpose of the overseas trip.	(b)
(c) Intended itinerary or destination.	(c)
(d) Intended duration of overseas trip.	(d) From: ________________________ To: ______________________
5. Name and Address of the Claimant's usual Doctor(s).	

DECLARATION AND AUTHORISATION

I hereby declare that the information given above are true and correct to the best of my knowledge and belief.

I hereby authorise any hospital, doctor or other person who has ever medically attended to me or any member of my family to furnish The Overseas Assurance Corporation Limited, or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all hospital or medical records. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

Claimant's signature: ______________________ Date: _____________ Insured's signature: ______________________ Date: ____________
(*See Note Below*)
Note: If (a) The Policyholder is claiming on his own belief or (b) the Claimant concerned is a Child under 18 years of age - only the policyholder's signature is required.

NB. No claim can be admitted unless medical certificate from a duly qualified and registered medical practitioner on the form below be furnished at the expense of the Insured.

SECTION D - ATTENDING DOCTOR'S STATEMENT

1. Name of Patient	2. NRIC No.	3. Date of Birth

Question	Answer
4. (a) If Injury: When did Accident occur? (b) If Sickness: When did symptoms first appear?	(a) (b)
5. (a) State the Nature of Injury or Sickness (*Describe complications - If any*). (b) Final Diagnosis. (c) Nature of Surgery (*if any*).	(a) (b) (c)
6. (a) When did the Patient first receive medical attention for this condition? (b) By Whom? Name of Doctor. (c) Address	(a) (b) (c)
7. Has the Patient ever had this or any similar condition?	☐ No ☐ Yes, details: ______________________________ ______________________________ ______________________________
8. Is the present condition of patient due to: (a) congenital anomaly? (b) nervous or mental disorder? (c) pregnancy/childbirth/infertility? (d) alcohol influence?	 (a) ☐ No ☐ Yes, specify: ______________________________ (b) ☐ No ☐ Yes, specify: ______________________________ (c) ☐ No ☐ Yes, specify: ______________________________ (d) ☐ No ☐ Yes, specify: ______________________________
9. Period of Hospitalisation.	Date Admitted: ______________ Date Discharged: _______________
10. Name and Address of Hospital Admitted.	
11. Are you the Patient's usual Doctor?	(a) ☐ No ☐ Yes If no, name and address of usual Doctor: ____ ____

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 Doctor: ___________________________

Date: ____________________________________

____
Signature & Official Stamp of Doctor

* to delete as applicable

Health