中国太平保险(新加坡)有限公司
CHINA TAIPING INSURANCE (SINGAPORE) PTE. LTD.
3 Anson Road #16-00 Springleaf Tower Singapore 079909
Tel: 6389 6111 Fax: 6222 1033
Website: www.sg.cntaiping.com Email: claimsdept@sg.cntaiping.com
Co. Reg. No. 200208384E

DOMESTIC MAID INSURANCE MEDICAL CLAIM FORM

To help us expedite your claim, please complete this form (including Attending Doctor's Statement) fully and return together with a copy of the (a) maid's work permit, (b) employment contract, (c) original medical invoices, (d) receipts and discharge summary within 30 days of discharge from the hospital

PART 1 – To be completed by Employer and Patient (Maid)

PARTICULARS OF INSURED			
Name of Employer		NRIC/Passport No.	
Policy No./Insurance Certificate No.		Contact Person/Telephone No. / Email address	
Address			
PARTICULARS OF PATIENT (MAID)			
Name of Patient (Maid)		Date of employment	
Marital Status	Nationality	Date of Birth (DD/MM/YYYY)	Sex
MEDICAL CONDITION OF PATIENT (MAID)			
Illness (Please provide details of illness including description of symptoms and attach hospital discharge summary for our reference. For female who is pregnant at time of hospitalization, please state the number of months of pregnancy.)		Accident (Please provide details on extent of injury and circumstances of the accident. Please also attach accident report)	
Date which symptoms first appeared	Duration of symptoms	Date of accident	Time of accident
Name and Address of attending Doctor		Did you have any surgical operation due to this Illness/Accident?	If yes, when was the operation? (DD/MM/YYYY)
Name and Address of referral Doctor/any other doctor consulted		Name and Address of regular Doctor	

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OTHERS		
Please advise the amount of government levy that the Insured (employer) pays monthly		
Are you entitled to or claiming reimbursement from any Insurance Company? If yes, please provide the following information:=		
Name of Insurance Company	Policy Number	Claim Amount
DECLARATION / AUTHORISATION		
I hereby declare that the above statements are true and complete to the best of my knowledge. I give consent to China Taiping Insurance (Singapore) Pte. Ltd. to seek information from any doctor, hospital or organization and authorized the provision of such information. A photocopy of this authorization shall be treated as valid document.		
Signature of Patient (Maid)	Date:	
I hereby declare that the foregoing particulars are true and correct.		
Signature of Employer	Date:	

DATA PRIVACY STATEMENT

In accordance with the Personal Data Protection Act 2012, I consent to the collection, use, disclosure of and/or process of my personal data (whether contained in the Claim Form or otherwise obtained) by China Taiping Insurance (Singapore) Pte Ltd, its affiliates and service providers (within or outside Singapore), for the purpose relating to the evaluation of the claim and to provide advice and information relating to the claim to me by Short Message Service (SMS), Multimedia Messaging Service (MMS) and fax messages (notwithstanding the registration of my telephone or mobile number in the Singapore's Do Not Call Registry)

Yes, I have read and agreed to the above Data Privacy Statement.

……
Signature of Claimant

Name:……

NRIC/FIN/Passport No. ……..

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ATTENDING DOCTOR'S STATEMENT

PART II (to be completed by attending Doctor/Surgeon)

Name of Patient	NRIC/Passport No.	Date of Birth(DD/MM/YYYY)
Name of hospital (admission)	Admission Date	Date of Discharge
Dates of 1st consultation and subsequent consultations	Symptoms presented by Patient	
Did the patient have any symptoms prior to consulting you? If yes, please specify the date which the symptoms first started prior to the date of 1st consultation with you. ☐ Yes: Date_____ ☐ No ☐ Not to my knowledge	How long has the illness/injury been existing prior to the date of 1st consultation with you?	

Has patient ever had the same or similar condition? ☐ Yes ☐ No ☐ Not to my knowledge	What is the cause of illness/injury?	Date of diagnosis	Diagnosis of illness or extent of injury
Treatment (s) provided		Surgery performed _____ _____ _____	Surgery Date (DD/MM/YYYY) _____/_____/_____ _____/_____/_____ _____/_____/_____

Please provide Name and Address of the Doctor(s) who had treated the Patient previously or referred Patient to you.

Was the condition of the Patient due to the following (please tick):	Yes	No	(If 'Yes", please provide details)
1. Congenital anomaly or genetic defects present at birth……			
2. Study and treatment of sleeping disorder……			
3. Dental treatment……..			
4. Sexually transmitted disease……			
5. AIDS or HIV infection……			
6. Functional disorder of the mind or nervous mental disorder.			
7. Alcoholism……..			
8. Drug addiction……			
9. Cosmetic or plastic surgery……			
10. Pregnancy, child birth, infertility or sub-fertility, miscarriage, abortion……..			
11. Self inflicted injuries……..			

Signature & Stamp of Doctor		Name and Address of Practicing Clinic / Hospital
Name of Doctor	Date	