UEN: T15FC0029B
GST Reg No: M90370081T
3 Temasek Ave., #16-01 Centennial Tower
Singapore 039190
Tel: +65 6804 6000
Fax: +65 6235 2616

Foreign Workers Medical Claim

Please fill in all blanks, check all applicable boxes, and sign and date at bottom. This document does not provide any coverage or amend any existing coverage

Policy No. ______________________________ Intermediary: ______________________________

1. Policyholder Paticulars / Insured Person

Policyholder's Name (Employer): ______________________________

Postal Address ______________________________

City ____________________ State ____________ Zip ______________

Email Address: ______________________________

Telephone No. (Office) ____________________ (Home Phone) ____________________

Name of Insured Worker: ______________________________

Passport/Work Permit No. ____________ DOB (DD/MM/YYYY): __________ Gender (M/F): _____

2. Claim Information

A. Hospitalisation Claim
Date of hospitalisation: from ____________________ to ____________________

B. Other Medical Or Surgical Expenses
Please indicate the nature and severity of claim: ______________________________
Please indicate the claim amount: ______________________________

3. Description Of Injury Or Illness

1. State the nature of injury / illness: ______________________________

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2. Date on which symptom was first discovered: ______________________________

3. Date on which symptom was first treated: ______________________________

4. Authorisation And Declaration By The Insured Worker

I, ______________________________ hereby authorise any hospital, medical practitioner, clinic, insurance office or any person(s) or organisation(s) who has/have attended to me for any reason, to disclose to GREAT AMERICAN INSURANCE COMPANY SINGAPORE BRANCH all information in respect of any illness or injury or which I have sustained and to provide copies of all hospital or discharge summary, medical records/certifications, including previous medical history. The information given herein is true and correct in accordance to the best of my knowledge.

______________________________ ______________________________

Insured Worker's Signature/Date Insured Employer's Signature/Date

NOTE:

1. The acceptance of this claim form is not to be construed as an admission of policy's liability.
2. All original final bills, certificates, supporting documents must be provided to substantiate your claim.
3. Great American Insurance Company, Singapore Branch hereby reserves all rights under the policy terms and conditions.