

## Group Hospital & Surgical Student Medical Insurance

Please complete all sections to facilitate the processing of your application. This form is issued without admission of liability and it must be completed and returned to us immediately, whether or not a claim is made. Any documentary proof or report required by Liberty shall be furnished at the expense of Policyholder or Claimant.

Please submit the following documents within 30 days from the date of discharge from hospital.

### For hospitalization in Government/Restructured Hospital

1. Duly completed and signed claim form (Page 2) and a copy of student pass
2. All original final hospital bills, doctor's/specialist's bills and receipts
3. Inpatient Discharge Summary
4. Inpatient Admission Report (if available)
5. Day Surgery Admission Report (if available)

### For hospitalization in Private Hospital/Hospital outside Singapore during school-related activities

1. Duly completed and signed claim form (Page 2) and a copy of student pass
2. All original final hospital bills, doctor's/specialist's bills and receipts
3. Medical Report from attending physician/specialist (page 3)
4. Inpatient Admission Report (if available)
5. Day Surgery Admission Report (if available)

Please submit the completed documents to:

SINGAPORE POST CENTRE P.O. BOX 15 Singapore 914001 (Student Medical Insurance Claim)

For Claim information and enquiries, please contact:

Ms Christina Chng @ 9760 2569  
Email: [christina@enrichadvisory.com](mailto:christina@enrichadvisory.com)

Ms Genna Ang @ 9671 5922  
Email: [genna@enrichadvisory.com](mailto:genna@enrichadvisory.com)

### Information of Policyholder

<b>Name of Private Education Institution (PEI):</b>	<b>Policy No.:</b>
<hr/>	<hr/>

### Information of Student Details

<b>Name of Student:</b>		<b>Gender:</b>
<hr/>		<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>NRIC/FIN No.:</b>	<b>Date of Birth:</b>	<b>Contact No.:</b>
<hr/>	<hr/>	<hr/>
<b>Mailing Address:</b>		
<hr/>		Postal Code ( )
<b>Email Address:</b>		<b>Course Start Date:</b>
<hr/>		<hr/>
<b>State nature of illness &amp; date upon which symptoms first occurred:</b>		<b>Plan No.:</b>
<hr/>		N.A
<b>Did you seek medical treatment prior to being diagnosed with the illness for which you are claiming now?</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please state the name of insurer and policy no.		
<hr/>		

# Student Medical Insurance

## Information of Student Details

Are you claiming from any other insurer in respect of this illness/injury? If Yes, please state the name of insurer and policy no.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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## Type of Accident

How did the accident happen?	Road-related	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Work-related	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Others	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Describe the nature of injuries sustained:			
Date & Time of Accident:	Place of Accident:		

## Claims Payment Details

Claim amount to be made payable to:	<input type="checkbox"/> Private education institution/school	<input type="checkbox"/> Student (uncrossed check)
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All check payments and claim documents will be delivered to the private institution/school.

## PERSONAL DATA PROTECTION

I, the Student, give consent to Liberty Insurance Pte Ltd and its employees, related companies, agents and service providers to collect, use and disclose my personal data for one or more of the purposes described in Liberty Insurance Pte Ltd's Data Protection Policy including but not limited to administering & processing my claim, communicating with me including via the telephone numbers I furnished via voice calls, text messages or faxes; investigations, underwriting, information-sharing, reinsurance, debt recovery, accounting, audit, regulatory, research & surveys. I have read and agreed to the terms of the full Policy at [www.libertyinsurance.com.sg/data-protection-policy/](http://www.libertyinsurance.com.sg/data-protection-policy/).

## DECLARATION

I, the Student, declare that I have complied with the conditions and warranties (if any) of the Policy and in no manner deliberately caused the said loss or damage or exaggerated the claim or sought unjustly to benefit by any fraud or wilful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty Insurance reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me. I authorize the release of any medical information necessary to process this claim.

\_\_\_\_\_  
Student's signature  
Date:

\_\_\_\_\_  
Name of PEI Administrator & signature  
PEI's Stamp:  
Date:

# Student Medical Insurance

## Medical Information (to be completed by the attending physician\*)

<b>Name of Patient:</b>		<b>NRIC/FIN No.:</b>
<b>Date when the patient first consulted you:</b>		<b>Prior to the first consultation with you, when did the patient first suffer the symptoms of the condition:</b>
<b>Presenting complaints:</b>		<b>Duration of illness/injuries at time of consultation:</b>
<b>Was the Patient referred by another physician?</b> If Yes, please provide details: Name of Physician: Address: Contact No.:		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>State your diagnosis of the illness/injuries:</b>		

## Investigations Done

<b>Blood Test</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Others, please specify:																														
<b>X-Ray</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No																															
If Yes, please furnish copies of the reports/investigation results																																	
<b>Type of surgical operation(s) done:</b>																																	
<b>Date of Admission:</b>	<b>Date of Discharge:</b>																																
<b>Is there any connection between the present condition and any other pre-existing illness or previous accident?</b> If Yes, please provide details:			<input type="checkbox"/> Yes <input type="checkbox"/> No																														
<b>Is the condition of the patient:</b> <table border="0"> <tr> <td>Congenital in nature</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Sexually transmitted disease</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Genetic or chromosomal disorder</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Related to cosmetic treatment</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Mental/psychiatric disorder</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Infertility related</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Drug addiction/alcoholism</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Treatment of teeth/gum tissue/oral cavity</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Self-inflicted injury</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Pregnancy related</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> </table>				Congenital in nature	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sexually transmitted disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Genetic or chromosomal disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Related to cosmetic treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mental/psychiatric disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Infertility related	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drug addiction/alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Treatment of teeth/gum tissue/oral cavity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Self-inflicted injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pregnancy related	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If any of the above is Yes, please provide details:																																	
<b>Will illness/injury require further follow-up treatment</b> If Yes, please provide details:			<input type="checkbox"/> Yes <input type="checkbox"/> No																														

## Investigations Done

Any other relevant information:

I hereby certify that I have personally examined and treated the patient for the above illness/injuries and that the facts are given above present my opinion of the patient's condition.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Physician

Name of Physician:

Contact No.:

Company Stamp: