LONPAC INSURANCE

LONPAC INSURANCE SINGAPORE PTE. LTD.
300 Beach Road #17-04/06 The Concourse Singapore 199555
Tel: (65) 6250 7388 Fax: (65) 6296 3767
www.lonpac.com.sg UEN: 202539075M GST No.: 202539075M

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 Certificate of Insurance, a copy of the maid's work permit, a copy of the employment contract, original medical invoices, receipts and discharge summary within 30 days of discharge from the hospital.

Part I – To be completed by Employer and Patient (Maid)

Particulars of Employer

Name of Employer	NRIC / Passport No.
Policy No. / Insurance Certificate No.	Contact Person / Telephone No.
Address	Email Address (*Used for claim matters if different from the proposal form*)

Particulars of Patient (Maid)

Name of Patient (Maid)			Date of employment
Marital status ☐ S ☐ M	Nationality	Date of birth	Gender ☐ F ☐ M

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 was pregnant at time of hospitalisation, please state the number of months of pregnancy.)		Accident (Please provide details on extent of injury & circumstances of the accident. Please also attach accident report.)	
Date when 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? ☐ Yes ☐ No	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

Data Privacy Statement

In accordance with the Personal Data Protection Act 2012, I/We consent to the collection, use, disclosure of and/or process my/our personal data (whether contained in the Claim Form or otherwise obtained) by Lonpac Insurance Singapore Pte. Ltd. ("Lonpac"), 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/us by Short Message Service (SMS), Multimedia Messaging Service (MMS) and fax messages (notwithstanding the registration of my/our telephone number(s) in the Singapore's Do Not Call Registry).

For more information on our Privacy Policy, please visit our website http://www.lonpac.com.sg/web/sg/privacy_policy.

I/we have read and agreed to the above Data Privacy Statement.

_____	_____
Signature of Patient (Maid)	Signature of Employer
_____	_____
Name:	Name:
_____	_____
NRIC / Passport No.	NRIC / Passport No.
_____	_____
Date:	Date:

Declaration / Authorisation

I hereby declare that the above statements are true and complete to the best of my knowledge. I give consent to Lonpac Insurance Singapore Pte. Ltd. to seek information from any doctor, hospital or organisation and authorise the provision of such information. A photocopy of this authorisation shall be treated as a valid document.

Signature of Patient (Maid): Date:

I hereby declare that the foregoing particulars are true and correct.

Signature of Employer Date:

Updated: 01 July 2026

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ATTENDING DOCTOR'S STATEMENT

THIS ATTENDING DOCTOR'S STATEMENT IS TO BE COMPLETED AT THE CLAIMANT'S EXPENSE IN ACCORDANCE WITH CONDITION 6C OF THE POLICY.

Part II (To be completed by attending Doctor / Surgeon)

Name of patient		NRIC / Passport No.	Date of Birth
Name of hospital (admission)		Admission date	Date of Discharge
Dates of first 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 first consultation with you. ☐ Yes: Date _____ ☐ No ☐ Not to my knowledge		How long has the illness/ injury existed prior to the date of first 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/YY) ____/____/____ ____/____/____ ____/____/____
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.)
Congenital anomaly or genetic defects present at birth	☐	☐	
Study and treatment of sleeping disorder	☐	☐	
Dental treatment	☐	☐	
Sexually Transmitted disease	☐	☐	
AIDS or HIV infection	☐	☐	
Functional disorder of the mind or nervous mental disorder	☐	☐	
Alcoholism	☐	☐	
Drug addiction	☐	☐	
Cosmetic or plastic surgery	☐	☐	
Pregnancy, childbirth, infertility or sub-fertility, miscarriage, abortion	☐	☐	
Self-inflicted injuries	☐	☐	

Signature & Stamp of Doctor		Name and address of practising clinic
Name of Doctor	Date	

Updated : 01 July 2026