

# DOMESTIC MAID INSURANCE MEDICAL CLAIM FORM



The issue and acceptance of this form and its accompanying documents (if any) does NOT constitute an admission by ERGO Insurance Pte. Ltd. that any part or the whole of the Claimant's claim is accepted. It also does not constitute a waiver of ERGO's rights in accordance with the terms and conditions of the Policy. Any documentary proof or report required by the Company shall be furnished at the expense of the Policyholder or Claimant.

This form must be completed truthfully and accurately, please answer in full all applicable questions. The list of documents required is not exhaustive and we reserve our right to request from you any additional information/ supporting documentation, as necessary. The submission of an incomplete form or insufficient information or supporting documents may delay the claims processing or result in the denial of your claim.

The completed form should be returned together with all supporting documents as soon as possible to the following address:

**Claims Department**  
**ERGO Insurance Pte. Ltd.**  
**5 Temasek Boulevard**  
**#04-05 Suntec Tower Five**  
**Singapore 038985**

In the event that this claim is deemed payable by us, it shall be payable to the relevant Policyholder/Employer or Claimant/Employee only and not to third parties.

- 1 POLICYHOLDER \_\_\_\_\_ LETTER OF GUARANTEE NO. \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ MASTER POLICY NO. \_\_\_\_\_  
 TEL (MOBILE) \_\_\_\_\_ RESIDENCE/OFFICE \_\_\_\_\_  
 EMAIL ADDRESS \_\_\_\_\_
- 2 PERSON UNDER TREATMENT \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_

3	(a) Nature of illness/Injury (b) Description of circumstances leading to the accident (c) Where / When did it commence?	
4	Name and address of the Doctor whom he/she first consulted	
5	Name and address of his/her usual Doctor	
6	Has he/she ever suffered before from the illness/injury in respect of which you are claiming?	
7	Have you previously claimed or received compensation under an Accident or Hospitalization Policy? If so, give particulars	
8	(a) Are you insured elsewhere? (b) If so, give the names of Company/Insurer and amounts you are entitled to claim	

I claim the amount of S\$ \_\_\_\_\_ being expenses incurred by me for treatment accordance with the particulars above and receipted bills attached.

**MEDICAL CERTIFICATE****NOTE: This form is completed by a registered Medical Practitioner**

Please State:

1	Full name of Patient	
2	What illness/injury the Patient has sustained	
3	(a) Has Patient had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No  (b) When did symptoms first appear or accident happen?  (c) When did Patient first consult you for this condition?	
4	Whether you are still attending the Patient?	
5	How the illness/injury were sustained?	
6	What previous illness / injury / disease / disability the Patient suffered from that caused or contributed to the illness / injury	
7	Details of any permanently disability the Patient sustained as a result of the illness/injury	
8	Full particulars of the operation illness or injury and the cause	
9	Name and address of the hospital/nursing home in which the Patient has been treated	

I hereby certify that the foregoing statements are correct.

Date \_\_\_\_\_ Signature \_\_\_\_\_  
Qualification \_\_\_\_\_  
Name \_\_\_\_\_  
Address \_\_\_\_\_

## DECLARATION, AUTHORIZATION AND PERSONAL DATA PROTECTION STATEMENT

**[Declaration]** I/ We declare that the particulars stated above are true, accurate and complete and I understand that if I have in this or in any further declaration in respect of this claim, made any false or fraudulent statement or suppress conceal or falsely state any material fact whatsoever my claim may be refused.

**[Authorization]** Where applicable, I/We hereby authorize any hospital, clinic, physician or any other person to disclose all information including copies of all hospital or medical records on the patient when requested by ERGO Insurance Pte. Ltd. (ERGO). I have noted that any illness, injury, consultations, medical history, prescriptions or treatment the medical report fee incurred will be borne by me. A copy of this authorization shall be considered as effective and valid as the original.

**[Personal Data Protection Statement]** I/We understand, acknowledge, agree and consent that:

- a. ERGO Insurance Pte. Ltd. (ERGO) may/will collect, use, disclose and/or process my/our personal data set out in this form and any other information provided by me (including that provided from sources other than myself) or possessed by ERGO for the purpose of enabling ERGO to provide me with services required of an insurance provider, such as evaluating, processing, administering, and/or managing of my relationship and policies with ERGO. This includes among other things policy servicing, processing, investigating, handling, administering and/ or settling my/our claim with ERGO or other insurers;
- b. ERGO may/will disclose and transfer my/our personal data to third parties, including but not limited to its affiliates, representatives, agents and third party service providers, lawyers/law firms, whether located within or outside Singapore, for one or more of the above purposes, and the said third parties may/ will subsequently collect, use, disclose and/or process my/ our personal data for or more of the above purposes;
- c. The personal data protection clauses herein are not exhaustive. I/We have read, understood and accept the terms of ERGO's Personal Data Protection Policy at <https://www.ergo.com.sg/pdpa>;

If I/We provide personal data of a third party (e.g. information of insured persons, beneficiaries, beneficial owners, dependents, customers, payees and/ or employees) to ERGO, I/We represent and warrant to ERGO that prior consents have been obtained from each of the third parties to provide such information.

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Name of Claimant

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NRIC/FIN/WORK PERMIT No.

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Signature of Claimant

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Date (DD/MM/YYYY)

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Signature of Policyholder

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Date (DD/MM/YYYY)