Maid Insurance

CLAIMS FORM

SECTION A: CLAIMANT DETAILS (Please attach a copy of the claimant's work permit)

Policy Number

Policyholder/Employer Name

Address Block No. Unit No. Street/Building Name

Postal Code

What is the best phone number to contact you?

What is your email address if we need to write to you?

Monthly Levy (SGD)

Claimant/Maid Name

Work Permit Number

Nationality

Date of birth

SECTION B: INCIDENT DETAILS

Date and time loss/accident/injury:

Location of loss/accident/injury

Detailed description of loss/accident/injury (Chronology of events - Please attach additional pieces of paper if necessary)

Are there any other insurance policies covering you for this loss/accident/injury? ☐ Yes ☐ No

Is this loss/accident/injury arising from a job-related incident? ☐ Yes ☐ No

If Yes, please give details of insurer, policy number and amount recoverable

SECTION C: SICKNESS OR INJURY DETAILS

Details of sickness or injured part (eg. Chin, Elbow, Ankle, etc) and type of injury (eg. Fracture, Cut, Bruise, etc)

Date first began

Date first treated

Date of previous treatment

Have you ever suffered from this injury/illness or a similar condition before? ☐ Yes ☐ No

SECTION D: DECLARATION AND AUTHORISATION

I declare that the information provided is, to the best of my knowledge, correct in every detail. I agree that if I have made any false or fraudulent statements or suppress, conceal or falsely state any material facts whatsoever, either now, or in the future, with regard to this claim, the Policy shall be void and all rights of recovery in respect of past or future claims, shall be forfeited.

On behalf of myself and all proposed Life Assured, I consent to Aviva (and Aviva related group of companies) collecting, using and/or disclosing my/our personal data (whether contained in this form or obtained from other sources; existing data in Aviva's record or to be collected in future) and transferring them to Aviva related group of companies, third party service providers, reinsurers, suppliers or intermediaries for the following purposes:

- To issue and administer my existing and/or new policy(ies) and/or account(s) with Aviva and such other purposes ancillary or related to the administering of the policy(ies) and/or account(s), including the processing of my/our personal data for underwriting purposes, payment of premiums and/or claims purposes;
- for statistical, research, compliance, audit and regulatory purposes.

For full details of the purposes of collection, use and disclosure of your personal data, please visit http://www.aviva.com.sg/pdpa.html.

I hereby authorise any hospital physician, other person, who has attended or examined me, to furnish Aviva Ltd., or its authorised representatives, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photo static copy of this authorisation shall be considered as effective and valid as the original.

Signature of Employer/Date

Signature of Patient/Date

Name of Employer

Name of Patient

Maid Insurance

PHYSICIAN'S STATEMENT

Attending Physician's Statement (To be completed by attending physician)

SECTION E: PATIENT'S MEDICAL RECORDS

Name of Patient

When did you first saw the Patient? (dd/mm/yyyy) Was the Patient referred to you? ☐ Yes ☐ No

Name and address of doctor recommending the referral

SECTION F: SICKNESS OR INJURY DETAILS

Is it due to sickness or injury? ☐ Injury ☐ Sickness

Is this a job related injury? ☐ Yes ☐ No

If it is due to an accident, please state date and time of accident: (dd/mm/yyyy) (time)

Was the patient under the influence of drugs or intoxicants at the time of accident? ☐ Yes ☐ No

Details of symptom(s) presented during the consultation (if treatment is due to injury, please provide details on nature and extent of injuries sustained.)

What is the underlying cause of illness/injury?

Exact Diagnosis

a. Primary | b. Secondary | c. Others

Describe surgical procedures or treatments rendered. If no surgery gas been performed, please state medication given.

Date of Admission | Date of Surgery performed | Date of Discharge

In your professional opinion, when do you think the patient first suffered from this illness?

Was the patient's illness/condition a congenital anomaly?

Was patient's illness/condition related to pregnancy, miscarriage, abortion, sterilisation, infertility or childbirth? If Yes, please specify condition and approximate date of commencement.

Was the patient's illness/condition due to self-destruction or intentional self-inflicted injury?

Was the patient's illness/condition a mental or nervous disorder?

Was this surgery for cosmetic reasons or dental treatment or an elective surgery?

Has the patient previously been treated for this illness/condition or any other serious disorder? ☐ Yes ☐ No

If Yes, please state

Date | Diagnosis & Date of Diagnosis | Details of treatment | Name of Doctor/Hospital

Is the patient still under your care for this condition? ☐ Yes ☐ No If No, date your service was terminated

SECTION G: DECLARATION

I hereby declare that the above answers are true to the best of my knowledge and belief.

Signature of Doctor/Address & Official Stamp of Doctor

Name of Doctor

Date (dd/mm/yyyy)

Designation

Name & Address of Hospital/Clinic

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