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| HOSPITALISATION & SURGICAL CLAIM FORM  **(NTU / NIE Claim Form)** | | |
| **IMPORTANT NOTES:** It is important to read the notes below before you complete the claim form. | | |
| **PREPARING REQUIRED DOCUMENTS**  Please complete this form in **FULL** and email the following documents to [claims@raffleshealthinsurance.com](mailto:claims@raffleshealthinsurance.com) within 90 days of discharge from the hospital:   * Copy of Final Summary and Itemised Hospital Bills. * For Government Restructured Hospitals: Copy of Inpatient Discharge Summary / Day Surgery Discharge Form / Histology Report * For Overseas Hospitals / Private Hospitals / Clinics: Copy of Attending Physician’s Statement (refer Page 4) * Please note that this form is **NOT** an acceptance of your claim. * Please note that incomplete submission of documents may delay the processing of your claims. | | |
| **TYPE OF ENTITIES** | | |
| |  |  | | --- | --- | | Nanyang Technological University (Undergraduate, excludes Singaporean) | Nanyang Technological University (Non-Graduating) | | Nanyang Technological University (LKCSoM) | Nanyang Technological University (NIE) | | Nanyang Technological University (Graduate) | Nanyang Technological University (NIEI) | | | |
| **CONTACT US** | **TYPE OF CLAIM DOCUMENTS REQUIRED (CHECK LIST)** | |
| **RAFFLES HEALTH INSURANCE PTE LTD**  (Registration No. 200413569G)  25 Tannery Lane  Singapore 347786  Tel: 6286 2866  Fax: 6812 6615  **Email:** [claims@raffleshealthinsurance.com](mailto:claims@raffleshealthinsurance.com)  **Website:** [www.rafflesmedicalgroup.com/ntu-ghs](http://www.rafflesmedicalgroup.com/ntu-ghs)  **Our Operating Hours:**  Monday to Friday 9.00am-6.00pm  Closed on Saturdays, Sundays and Public Holidays | **Hospitalisation and/or Surgical**  Completed Claim Form  Copy of Final Hospital Bill (the hospital will usually send  the final bill to the patient about 2 to 3 weeks after  discharge  Copy of Pre and Post Hospitalisation/Surgery Bills  Copy of Discharge Summary/Day Surgery Authorisation  Form  LOG Request Form (if request for LOG) | **Outpatient Specialist, A&E, Physiotherapy, TCM or Mental Health**  Completed Claim Form  Original Medical Bills  Copy of Referral Letter from A&E or  Fullerton Health @ NTU |

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| **SECTION 1: PARTICULARS OF INSURED** | | | | |
| Name of Student (please write in capitals, as per bank account) | | | Address (Singapore) | |
| Gender  F M | NRIC/ FIN No. | Date of Birth  (DD/MM/YYYY) | Email Address | |
| Matriculation No. | | Matriculation Date  (DD/MM/YYYY) | Expected Date of Graduation/ Completion of Course  (DD/MM/YYYY) | Mobile/Telephone No. |

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| **SECTION 2: OTHER INFORMATION** (Please DO NOT state the bank details of another person) | | | |
| Reimbursement for approved claims will be credited into the student’s bank account    **Please select one for claim payment:**  Telegraphic Transfer  Giro (provide details below)  *For Telegraphic transfer, all administrative costs from the bank will be chargeable to the student.* | | | |
| Name of Account Holder | Name of Bank | Name of Intermediary Bank | Account No. |
| Bank Address Including Branch (*For Telegraphic Transfer*) | | Swift Code/ IBAN (*For Telegraphic Transfer*) | |

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| **SECTION 3: DETAILS OF ILLNESS OR INJURY** | | | | | | |
| **A. Hospitalisation due to Illness** | | | **B. Hospitalisation due to Injury from Accident** | | | |
| Nature of Illness/Final Diagnosis    Describe Symptoms and date symptoms first appeared  Type of Operation performed (if applicable) | | | Describe how it happened and state the extent of the injury (Please enclose a copy of the police report, if any.) | | | |
| Date illness first treated/Date of first consultation  (DD/MM/YYYY) | Name of doctor/hospital the patient first consulted for the illness | | Date of Accident  (DD/MM/YYYY) | Time of Accident  (HH : MM) | Place of Accident | |
| Is the illness job-related? *(for working spouse only)*  Is the illness due to pregnancy, miscarriage or fertility? | | No Yes  No Yes | Is the injury/accident job-related? *(for working spouse only)*  Is it claimable under Workmen’s Compensation? *(for working spouse only)* | | | No Yes  No Yes |
| Are you making a claim from any other insurance companies?  No  Yes, please provide information below:  Name of insurance company Type of Policy Policy No \_\_\_\_\_\_\_\_\_\_\_\_  **\***  Please submit a copy of the other insurance company’s claim settlement letter or payment voucher | | | | | | |

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| **SECTION 4: Declaration & Consent** | | |
| **PERSONAL DATA NOTICE**   1. I understand, acknowledge, agree and consent that Raffles Health Insurance Pte Ltd (**“RHI”**) or its representatives are permitted to: 2. collect, use, disclose and/or process my personal information set out in this form and any other personal information provided by me or from other sources such as employer, intermediaries, medical organisations, third party providers or agents (which may be sited outside of Singapore), other insurance companies (collectively the **“Personal Information”**) for the purpose(s) set out below; and/or 3. disclose and transfer such Personal Information to other sources such as other departments in RHI, employer, intermediaries, medical organisations, banks, CPF Board, reinsurers, third party service providers or agents (which may be sited outside of Singapore), other insurance companies, for the purpose(s) set out below: 4. **Purpose(s)** 5. processing, handling and/or dealing with my claims including the settlement of the claims and any necessary investigations relating to the claims; 6. investigating the accident and/or my claims; 7. carrying out and/or dealing with my instructions or responding to any enquiries by me; 8. administering my claims (including the mailing of correspondence, statements, invoices, reports or notices to me, which could involve disclosure of certain personal data about me to bring about delivery of the same as well as on the external cover of envelopes / mail packages); and/or 9. complying with applicable law in administering, processing, handling and/or dealing with my claims. 10. I further acknowledge and consent that my Personal Information may be collected, used and/or disclosed by RHI for : 11. carrying out due diligence activities in accordance with legal or regulatory obligations or risk management procedures required by law or the Monetary Authority of Singapore (**“MAS”**) or implemented by RHI; 12. responding to requests for information from other insurance companies, MAS, General Insurance Association of Singapore (**“GIA”**), Life Insurance Association of Singapore (**“LIA”**) or other relevant government agency/authority (such as police).   **DECLARATION & AUTHORISATION**  1. I hereby declare that the information on this form and any documents attached to it is correct and complete and I have not withheld any information that could affect this claim.  2. I hereby authorise any hospital, physician or other person who has attended to me to furnish Raffles Health Insurance Pte Ltd or its representatives all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment, copies of all hospital or medical records.  3. I agree that a photocopy of this authorisation shall be considered as effective as the original. | | |
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| **X**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature & Name of Patient  Date: | **X**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature & Name of Parent  (Parent to sign if patient is below 21 years old)  Date: |  |