

SECTION A - POLICY DETAILS			
Insured (Policyholder/Company):			
Policy No.		Admission/Surgery Date	
Insured Contact Person		Contact No./Email	

SECTION B - DECLARATION, AUTHORIZATION AND PERSONAL DATA PROTECTION STATEMENT	
Declaration	I / We declare that the particulars stated above are true, accurate and complete and I / we understand that if I / we 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 / our 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 / We have noted that any illness, injury, consultations, medical history, prescriptions or treatment the medical report fee incurred will be borne by me / us. A copy of this authorization shall be considered as effective and valid as the original.
Personal Data Protection Statement	<p>I / We understand, acknowledge, agree and consent that: -</p> <ul style="list-style-type: none"> 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/us (including that provided from sources other than myself/us) or possessed by ERGO for the purpose of enabling ERGO to provide me/us with services required of an insurance provider, such as evaluating, processing, administering, and/or managing of my/our 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; d. 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.

SECTION C - UNDERTAKING FOR MEDICAL DOCUMENT	
Declaration	I / We declare that all the submitted medical documents are true, accurate and complete and I / we understand that if I / we have in this or in any further declaration in respect of this claim, made any duplicate, false, fraudulent or suppress conceal or falsely state any material fact whatsoever my / our claim may be refused.
Definition	Medical document shall mean e-bill and any softcopy invoices, certificate, memo and/or reports issued by a Singapore Public & Private Health Institutions, Government Polyclinics, Private Clinics, prescribed by a Singapore Registered Medical Practitioner and/or Others subject to policy's terms and conditions.
Rights of Insurer	<p>I / We understand, acknowledge, agree and consent that: -</p> <ul style="list-style-type: none"> I. ERGO reserves the rights to contact the institution directly for validation of such medical document's authenticity; II. ERGO retain the rights to request for the original bill / certified true copies whenever necessary within 1 year from the date of receipt of such medical document; III. ERGO can/may denied this or any related claims, recover any amounts disbursed, to impose additional charges or recovery any costs incurred in the event of fraudulent and/or multiple claims made.

	Name of Claimant.
	NRIC/FIN/Work Permit No.
	Signature of Claimant & Date (DD/MM/YYYY)

	Name of Insured's Authorised Representative
	Designation of Insured's Authorised Representative
	Signature of Insured's Authorised Representative & Date (DD/MM/YYYY)

SECTION D - MEDICAL CONDITION FORM (To be completed by attending inpatient physician/surgeon)			
Patient Name & Gender <div style="text-align: right;"> <input type="checkbox"/> Male <input type="checkbox"/> Female </div>	Patient NRIC/FIN/WORK PERMIT NO.	Patient Age	
Nature of Condition/Injury: -			
Surgical Procedure/Treatment rendered:-			
If the patient was previously treated/consulted for his/her condition, kindly elaborate how long has patient been diagnosed or sought treatment:-			
Please Tick accordingly		YES	NO
Is above surgical procedure/treatment medically necessary?			
Is above surgical procedure/treatment solely for investigative and/or diagnosis purpose?			
Is the sickness/injury occurred/manifested whilst patient was at work or in his/her working premises/environment?			
Is the sickness/injury occurred/manifested whilst patient was engaging in a sport in a professional capacity or extreme sport events or criminal act?			
Is the condition arising from an assault provoked by the patient?			
Is the condition pertaining to Pregnancy, Infertility, Sterilization, Contraception or Childbirth?			
Is the condition related to birth defects, congenital abnormalities and/or hereditary conditions and disorders?			
Is the condition due to substance abuse (including alcohol), substance dependence or chemical dependence?			
Is the condition due to intentional self-inflicted injury (including tattooing or body piercing), suicide or attempt thereof or arising from psychological, emotional, and mental and behavioural conditions?			
Is the condition directly or indirectly caused by any kind of infectious disease, illness, viral, bacterial or any other kind of infection howsoever caused and transmitted?			
Is the condition listed in the Infectious Diseases Act?			
Does the patient require quarantine/isolation?			
Physician's/Surgeon's Signature & Date		Physician's/Surgeon's Qualification(s)	