

FOREIGN WORKERS MEDICAL CLAIM FORM

Agency _____

Policy No _____

SECTION 1 - PARTICULARS OF INSURED EMPLOYER / INSURED PERSON

A.1. Name of Insured Employer : _____

2. Address : _____

3. Email Address : _____

4. Tel : (O): _____ (H) : _____ (H/P) : _____

B. 1. Name of Insured Worker : _____

2. Passport/Work Permit No. : _____ Date of Birth: _____ Sex: (M/F): _____

SECTION 2 – CLAIM

A. HOSPITALISATION CLAIM

Dates of Hospitalisation : From _____ To _____

B. OTHER INCURRED MEDICAL OR SURGICAL EXPENSES

Please state the nature and amount of fees incurred :

Nature of Claim : _____ Amount Incurred : _____

SECTION 3 - DETAILS OF ILLNESS / INJURY

1. State nature of illness/injury : _____

2. Date symptoms first commenced : _____
3. Date condition was first treated : _____

SECTION 4 - AUTHORISATION AND DECLARATION BY INSURED WORKER

I, _____ hereby authorise any hospital, surgeon, medical practitioner, clinic, insurance office or other person or organisation who has attended to me for any reason, to disclose to EQ INSURANCE COMPANY LIMITED any and all information with respect to any illness or injury and to provide copies of all hospital or medical records/certifications, including earlier medical history. The information given is true and correct to the best of my knowledge and belief.

Insured Worker's Signature / Date

Insured Employer's Signature / Date

Please note:

1. The acceptance of this form is NOT an admission of liability on the part of the Company.
2. All original final bills, certificates, supporting documents should be provided to substantiate your claim.