



**GROUP MEDICAL INSURANCE CLAIM FORM**

SINGAPORE LIFE LTD.  
 Group Life & Health Claims  
 5 Straits View, #01-18/19  
 Marina One The Heart, Singapore 018935  
 Tel: 6827 8030  
 Company Registration No. 196900499X

**SECTION 2: MEDICAL REPORT (TO BE COMPLETED BY ATTENDING PHYSICIAN / SURGEON)**

For admission to Private Hospital or Hospital outside Singapore, claimant must arrange to have this section completed by the Attending Physician when submitting a claim.

Patient Information																															
Policy No:	Name of Company:																														
Name of Patient:	NRIC/Passport No: <span style="float: right;">Admission Period:</span>																														
Nature of Illness	Nature of Treatment / Surgery																														
01) Final Diagnosis (Based on ICD 10) of illness or extend of Injury DRG Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ICD Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ICD Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date of Diagnosis: _____	05) Date of surgical procedure or treatment rendered : _____ Operation Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Operation Table <input type="text"/> <input type="text"/>																														
02) Given the aetiology of the condition, please state the estimated date of such condition would be in existence.	06) Describe the surgical procedure or treatment rendered. If no surgery was performed, please state treatment / medication given																														
03) What is the cause of illness / injury?	07) If excision was performed, please indicate the size of the lesion / tumor. (Please attach a copy of the Histology Report)																														
04) What is the anatomy of this illness?	08) Name of a) Physician _____ b) Surgeon _____ c) Anesthetist _____																														
09) Is the condition/treatment related to: a) Pregnancy or childbirth b) Abortion or Miscarriage c) Infertility or Sub-fertility Condition d) Congenital Anomaly e) Genetic or Chromosomal Disorder f) Mental or Psychiatric Condition g) Cosmetic Surgery h) Is the surgery for correction of short sightedness? i) Is the surgery for dental purposes?	<table border="0" style="width:100%;"> <tr> <td style="text-align: center;">Yes</td> <td style="text-align: center;">If "Yes", please elaborate.</td> <td style="text-align: center;">No</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>a) _____</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>b) _____</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>c) _____</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>d) _____</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>e) _____</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>f) _____</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>g) _____</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>h) _____</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>i) _____</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	Yes	If "Yes", please elaborate.	No	<input type="checkbox"/>	a) _____	<input type="checkbox"/>	<input type="checkbox"/>	b) _____	<input type="checkbox"/>	<input type="checkbox"/>	c) _____	<input type="checkbox"/>	<input type="checkbox"/>	d) _____	<input type="checkbox"/>	<input type="checkbox"/>	e) _____	<input type="checkbox"/>	<input type="checkbox"/>	f) _____	<input type="checkbox"/>	<input type="checkbox"/>	g) _____	<input type="checkbox"/>	<input type="checkbox"/>	h) _____	<input type="checkbox"/>	<input type="checkbox"/>	i) _____	<input type="checkbox"/>
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<input type="checkbox"/>	i) _____	<input type="checkbox"/>																													
Medical History																															
10) Please provide the name and address of referring doctor if patient was referred to you.	15) If there is no symptoms presented, what has prompted the patient to see you?																														
11) When did the patient first consult you for this condition?	16) Please specify the approximate date of discovery of the illness or injury																														
12) Nature and Date of Treatment rendered	17) How long has the illness / injury existed prior to consulting you?																														
13) What were the symptoms/complaints prior to consulting you?	18) Has the patient ever had the same or similar condition / symptom? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not to my knowledge																														
14) Please indicate the nature of Symptoms and date Symptoms first started	19) Doctors previously consulted by the patient for the above condition. Name of Doctors: _____ First Consultation: _____ Name of Clinic: _____ Address: _____																														
20) Is the patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please state the estimated duration that patient needs to follow up with you.	If No, please give termination date of service and furnish name and address of doctor if the patient has been referred to another doctor for follow up																														
_____ Signature of Physician / Surgeon	_____ Date																														
_____ Name / Designation	_____ Name and Address of Clinic / Hospital & Stamp																														