Singapore Airlines Claim Form

Personal Accident and Medical Related

1. Date & time the illness / injury occurred: / / .	2. Place where the illness / injury occurred:
3. Date of hospital admission : / /	4. Date of discharge : / /
5. Please provide full description of your illness / injury. If injury, please advise how it happened including precise details of the location, the time and any circumstances or causes that led to the incident or accident (eg, inoperative lighting, wet floor):	
6. If your medical claim was a result of an injury, was a third party involved? Yes ☐ No ☐	6.1 If yes, please provide the third party's name, address, contact number and details of their insurer/solicitor
7. Date of onset of symptoms: / /	7.1 Diagnosis:
7.2 Have you suffered from the same illness before? Yes ☐ No ☐	7.3 If yes, please provide details :
8. Name of the Hospital / Clinic :	8.1 Hospital / Clinic contact number :
9. Name of your usual doctor :	9.1 Address of your usual doctor :
9.2 Contact number	9.3 Fax number

10. Medical and additional expenses (continue on a separate sheet if necessary).
Please provide the following details. Kindly take note that exchange rate will be calculated based on monthly average for that currency unless bank statement or Bureau de Change receipt is provided.

Receipt No	Date Issued	Description of Expenses	Receipt Issued By	Currency	Amount Claimed	Exchange Rate	Paid (Yes / No)

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Medical Certificate (for Personal Accident and other Medical Related claims)

This form is to be completed by the registered General Practitioner (GP) or Specialist of the person whose illness / injury / death has caused the claim.

Note:
- Any charges made for its completion is the responsibility of the patient or claimant.
- To assist us in expediting the claim, please answer all questions.
- All information is treated as private and confidential

1. Name of the patient:	
2. Identification No / Passport No:	3. How long have you been the patient's GP / Specialist :
4. Give full descriptions of illness or injury:	
5. Onset date of symptoms:	6. Date first consulted:
7. Diagnosis:	8. Date of diagnosis:
9. Is the above illness / injury due to / related to any underlying condition ? please advise any previous medical history relevant to the above condition:	

10. Prior to admission to hospital / clinic was the patient :	**If yes, please provide further details**
10.1 On a hospital waiting list / on appointment Yes ☐ No ☐	
10.2 Taking any medication relevant to the above condition Yes ☐ No ☐	
10.3 Undergoing any tests or waiting for results of any tests Yes ☐ No ☐	
10.4 Aware of the condition Yes ☐ No ☐	
10.5 Given a terminal diagnosis Yes ☐ No ☐	
10.6 Under the influence of any alcohol or drugs which may have contributed to the accident or illness. Yes ☐ No ☐	

11. Is the insured undergoing routine medical check up :	
12. Is the the treatment related to dental : If yes is it affecting a sound and natural teeth, please describe :	
13. When would patient be fit to travel again :	12. Please provide the patient's state of health at the time the holiday was purchased:

Doctor's Declaration

I have examined the patient and / or referred to their medical records and declare that the information given is correct and no relevant details have been withheld.

Name of Doctor :	Date of Signed :
Contact Number :	Signature & Hospital/Clinic Stamp :

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