MAID*ASSURE* (MA)
CLAIM FORM

Agency/Broker:
MA Policy No.:

IMPORTANT

1. This form is issued and/or accepted without admission of liability.
2. The insured must complete this form fully and accurately and submit together with the supporting documents **within 30 days of discharge from hospital**.
3. The list of documents required is not exhaustive and we reserve the right to request from you any additional information/documentation, as necessary.

1. Particulars of Policyholder

Name of Employer *(as in NRIC/Passport)*				GST Registered	◯ Yes ◯ No
				GST No. *(if Yes)*	
Address				Date of Enrolment/Cover	
Occupation				Plan Type	
Contact No. (HP)		(O)		Email	

2. Details of Domestic Worker

Name *(as in NRIC/Passport)*		NRIC/Passport/WP/FIN No.	
Gender	◯ Male ◯ Female	Work Permit No.	
Date of Birth *(dd/mm/yyyy)*		Date of Employment	
Nationality		Monthly Wages	

3. Medical Details

Date of symptoms first appeared *(dd/mm/yyyy)*	Has the illness been treated previously?	◯ Yes ◯ No
	If Yes, Name & Address Of Physician and Date of First Treatment	
Diagnosis & Symptoms		
Are there any known pre-existing conditions when the employee was employed? *If Yes, please provide details*		◯ Yes ◯ No

Name of Hospital	
Hospital Admission Date *(dd/mm/yyyy)*	
Hospital Discharge Date *(dd/mm/yyyy)*	
Date of Surgery Performed *(dd/mm/yyyy)*	
Types of Surgery performed *(if applicable)*	
Any post hospitalization treatment required?	◯ Yes ◯ No

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4. Accident Details

Date/Time of Accident	Place of Accident

Describe how it happened and state the extent of the injury

Are there any known pre-existing conditions when the domestic worker was employed (*If yes, please provide details)*	◯Yes ◯No

Name of Hospital:	
Hospital Admission Date *(dd/mm/yyyy)*	
Hospital Discharge Date *(dd/mm/yyyy)*	
Date of Surgery Performed *(dd/mm/yyyy)*	

Any post hospitalization treatment required?	◯Yes ◯No
Any surgery performed? *(If yes, please provide details)*	◯Yes ◯No

5. Particulars of Alternative Help (if applicable)

Name *(as in NRIC/Passport)*		NRIC/Passport/WP/FIN No.	
Gender	◯Male ◯Female	Contact No.	
Engaged Helper through Agency? *(If yes, please provide information below)*			◯Yes ◯No
Name of Agency: Agency's Contact No.:			
No. of days worked:		Total amount paid:	

6. Other Insurance or Compensation

Are you making a claim from any other insurance companies? *(If Yes, please provide information below)*	◯Yes ◯No
Name of Insurance Company: Type of Policy: Policy No.:	
REMARKS:	

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7. Type of Claims & Supporting Documents needed

Please tick the types of claim you are sending us and the documents you are attaching for this claim. We may ask for more documents to assess the claim.

TYPE OF CLAIMS	DOCUMENTS SUBMITTED
☐ Medical / Critical Illness	☐ Original Medical Bills ☐ Original Medical Receipts ☐ Police Report ☐ Investigation Results in the event of accident or injury
☐ Hospital & Surgical	☐ Original Hospital bills & Receipts ☐ Invoice / Bill for Alternative Employment ☐ In-patient discharge summary ☐ Medical / Doctor's Report / Attending Physician's Statement ☐ Police Report ☐ Investigation Results in the event of accident or injury
☐ Total Permanent Disability	☐ Medical / Doctor's Report / Attending Physician's Statement ☐ Police Report ☐ Investigation Results in the event of accident or injury
☐ Loss of Life (Death)	☐ Police report ☐ Death certificate ☐ Autopsy report ☐ Toxicological report ☐ Coroner's findings
☐ Repatriation / Termination Expenses	☐ Death certificate ☐ Letter from doctor stating permanent disablement / prolonged terminal / serious illness preventing the maid from carrying out her duties ☐ Invoices of expenses claimed

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DECLARATION

i. I declare that the above statements and answers are true and complete to the best of my knowledge and belief.
ii. I hereby authorize any hospital, physician, person or organization to disclose when requested to do so by ECICS Limited, all information with respect to any illness, injury, medical history, consultations, prescription or treatments and copies of all hospital or medical records.
iii. A photocopy of this authorization shall be considered as effective and valid as the original.

NOTICE: Personal Data Protection Policy

We/I understand, acknowledge, agree and consent that:

a) ECICS Limited (the "Insurer") is permitted to collect, use, disclose and/or process my personal data/personal information set out in this Claim Form and any other personal information provided by me or possessed by ECICS Limited (collectively the "Personal Information") and disclose and transfer such Personal Information to the Insurers' lawyers/law firms, Insurers' doctors, the Monetary Authority of Singapore and any relevant government agency/authority (such as the police), for the purpose(s) of:

(i) processing, handling and/or dealing with my claims including the settlement of the claims and any necessary
(ii) investigations relating to the claims;
(iii) investigating my claims
(iv) carrying out and/or dealing with my instructions or responding to any enquiries by me;
(v) 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
(vi) complying with applicable law in administering, processing, handling and/or dealing with my claims.

(collectively the "Purposes")

b) the Insurers' lawyers/law firms, insurer's doctors, adjuster may/are permitted to collect, use, disclose and/or process my Personal Information for one or more of the above Purposes; and

c) my Personal Information may/can be disclosed by any of the Insurers and/or GIA to their third party service providers or agents (including their lawyers/law firms), which may be sited outside Singapore, for one or more of the above Purposes.

Note: ECICS Limited Privacy Policy can be found at http://www.ecics.com.sg/pers.htm

Signature of Insured Person/Employee	Signature of Employer
Date:	Date:

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ATTENDING PHYSICIAN'S STATEMENT

IMPORTANT: This form is to be completed by Attending Doctor / Surgeon and at the claimant's expense

Name of Patient		Name of Employer	
Date of Diagnosis		Cause of Injury	◯ Illness ◉ Accident ◯ Others
Please provide full description of diagnosis			

Are you the patient's usual medical doctor?	◯ Yes ◯ No
Over what period does your record extend?	Start Date: End Date:
Was the condition of the patient due to the followings *(please tick)*	*Please state the condition and elaborate fully*
☐ Congenital anomaly or genetic defects present at birth ☐ Study and treatment of sleeping disorder ☐ Dental treatment ☐ Sexually transmitted disease ☐ AIDS or HIV infection ☐ Functional disorder of the mind or nervous mental disorder ☐ Alcoholism ☐ Drug addiction ☐ Cosmetic or plastic surgery ☐ Pregnancy, child-birth, infertility or sub-infertility, miscarriage, abortion ☐ Self-inflicted injuries	
Is the insured's present illness or condition caused by any other underlying disorders? *(If Yes, please give details)*	◯ Yes ◯ No
Is ☐ illness / ☐ accident arising from employment? *(If Yes, please elaborate fully)*	◯ Yes ◯ No

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Was the condition caused by an accident? *(If Yes, describe the accident)*	◯Yes ◯No
Are you aware of anything in the previous medical history of the patient which might have contributed directly or indirectly, to the occurrence of the accident, or which may be likely in any way retard patient's recovery from it? *(If Yes, please elaborate fully)*	◯Yes ◯No
Is condition originated before symptoms become apparent to the patient, please indicate when in your view this condition began to develop. *(If Yes, please elaborate fully)*	◯Yes ◯No
Has the patient been treated previously for the same condition? *(If Yes, please state when)*	◯Yes ◯No
FOR HOSPITALISATION TREATMENTS (if applicable)	
Was any surgery performed for this condition? *(If Yes, please elaborate fully on surgical procedures and treatments rendered)*	◯Yes ◯No
Any permanent ◯PARTIAL / ◯TOTAL disablement sustained by patient as a result of the ◯illness / ◯injury? *(If Yes, please elaborate fully)*	◯Yes ◯No
Admission date *(dd/mm/yyyy)*:	
◯Actual / ◯Expected date of discharge *(dd/mm/yyyy)*:	
What were the investigations done to confirm the diagnosis?	
Please advise the number of days that patient is expected to be necessarily and entirely confined to House or Hospital as the sole and direct result of the ◯injuries / ◯illness sustained;	
To House days To Hospital days	

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Please provide details of treatment that has been provided.
What are the follow up outpatient treatments required.

I hereby certified that the foregoing statements are correct.

Date: _____

Signature & Stamp of Doctor:_____

Name of Doctor: _____

Name & Address of Practicing ◉**Clinic /** ○**Hospital**

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_____

_____

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