FWD

GROUP OUTPATIENT CLAIM FORM

Important Notes:

1. The acceptance of this claim form is not an admission of liability by FWD Singapore Pte Ltd.
2. Claims should be submitted within 30 days from the date of consultation.
3. Documents required
   - Outpatient claim form fully completed and signed.
   - Final and Original itemised receipts or bills, with the patient's name, date of consultation, diagnosis and treatment clearly stated.
   - Copy of referral letter from the attending GP is required for Specialist claims (if applicable).
   - Copy of the attending doctor's prescription letter is required for medication purchased from the pharmacy.
   - Claims for Diagnostic tests must be supported by a copy of the test results and referral letter from the attending doctor.
4. Please note that incomplete submission of documents will delay the processing of the claim.

1. Particulars of Employee

Name of Employer	
Name of Employee	
NRIC/FIN Number	Date of Birth (dd/mm/yyyy)
Occupation	Employment Start Date (dd/mm/yyyy)
Contact Number	Email Address

2. Particulars of Patient (to complete if patient is spouse or child of employee)

Name of Patient	
NRIC/FIN Number	Date of Birth (dd/mm/yyyy)
Relationship to Employee ☐ Spouse ☐ Child	Marital Status ☐ Married ☐ Single
Gender ☐ Male ☐ Female	Cover Effective Date (dd/mm/yyyy)
Occupation	

3. Claim Details

Date of Consultation (dd/mm/yyyy)	Name of Hospital/ Clinic	Claim Type*	Bill Amount	Diagnosis/Treatment/Procedure (compulsory)	Work-Related?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

* **Claim Type**
GP = General Practitioner, SP = Specialist, COB = Chronic Outpatient Benefit, PRE = Pre-Hospitalisation, POST = Post-Hospitalisation

4. Please complete this section if you have submitted claims incurred at FWD Panel Clinics

The FWD member card should be used for visits at FWD panel clinics. Please indicate the reason why you had paid in cash.

☐ New Employee. Yet to receive card.

☐ Clinic collected cash.

☐ Others (please specify) ____________________________________

5. Other Information

Have you claimed or do you intend to claim from any other insurer, employer or third party? ☐ Yes ☐ No
If "Yes", please provide details below and submit a copy of the settlement letter or payment voucher.

Name of Party claimed from	Date claimed (dd/mm/yyyy)	Amount claimed

6. Declaration & Authorisation

a. I declare that all the information/documents provided are true and accurate to the best of my knowledge and I have not withheld any information that could affect this claim nor filed this claim with/against any other parties.

b. I authorise any person or organisation who has relevant information on this claim, including but not limited to any medical practitioner, health care provider, insurance company and investigative agencies, to release and exchange such information (including personal health information) requested by FWD Singapore Pte Ltd and/or its claims service providers.

c. I authorise FWD Singapore Pte Ltd and its claims service providers to collect, use, disclose and to exchange with the persons or organisations any information (including health information).

d. I am authorised to disclose information (including personal health information) about the insured members if this claim is made on behalf of them.

e. I further give my consent for FWD Singapore Pte Ltd to use the personal data given in this claim form or otherwise obtained and disclose such data to FWD's authorised staff, associated individuals and/or companies or any independent third parties (within or outside Singapore) who will provide claims administrative, advice and/or information or claims services in relation to this claim. I understand and give consent for FWD Singapore Pte Ltd to use my personal data for audit, business analysis, reinsurance purposes and for the purposes set out in FWD's Privacy Policy which can be found at www.fwd.com.sg.

f. I agree that a photocopy or electronic version of this authorisation shall be as valid as the original.

Signature of Employee	Signature of Patient (employee to sign if patient below age 21)
Date (dd/mm/yyyy)	Date (dd/mm/yyyy)