FWD insurance

Celebrate living
fwd.com.sg

COVID-19 insurance claim form

Important

1. Please provide the claim documents listed below to FWD Singapore Pte. Ltd. based on the type of claim you're making.
2. Fill this form and submit it, along with your documents, to **makeaclaim@fwd.com**
3. Please answer every question.
4. We reserve the right to request further information, reports or documents we consider necessary to assess your claim.
5. We will inform you if we need further information, reports or documents.
   Do note the cost of obtaining any information, reports or documents will be borne by the Policyholder.

Please provide these documents for post hospitalisation cash benefit and Daily cash allowance claim

1. This completed claim form.
2. A copy of the final hospital bill.
3. A copy of the inpatient discharge summary.
4. A copy of relevant medical reports, diagnostics and laboratory reports.
5. A copy of a mandatory government stay home order or quarantined order (if applicable).

Please provide these documents for a death claim

1. This completed claim form.
2. A copy of the death certificate.
3. Proof of relationship between the claimant and the policyholder such as a marriage certificate or birth certificate.
4. A copy of the inpatient discharge summary (if applicable).
5. A copy of relevant medical reports, diagnostics and laboratory reports.
6. A copy of a mandatory government stay home order or quarantined order (if applicable).

Important

We are not admitting to any legal responsibility by accepting this claim form.

Type of claims

☐ **Post hospitalisation cash benefit**

☐ **Daily cash allowance (Due to ICU admission)**

☐ **Death claim**

Section 1: claim form to be completed by the claimant

Policy number

Personal details of insured

Full name (as in NRIC/FIN)

NRIC/FIN number

Gender	
Occupation	
Industry (Please select one)	☐ Transportation & storage ☐ Food ☐ Health & social services ☐ Others
Name of employer	
Address of employment	
Date the first symptoms started	
Description of first symptoms	
Date of first medical consultation for these symptoms	
Period of stay home order or quarantine	From (dd/mm/yyyy) To (dd/mm/yyyy)
Final diagnosis	
Date of diagnosis	
If hospitalised, please indicate The name of the hospital	
Date of admission	
Date of discharge	
Name and address of Doctor or specialist That attended to You during your Hospitalisation	

Recent travel history (from january 2020 onwards)

List of countries visited

<country 1>

From (dd/mm/yyyy) To (dd/mm/yyyy)

<country 2>

From (dd/mm/yyyy) To (dd/mm/yyyy)

<country 3>

From (dd/mm/yyyy) To (dd/mm/yyyy)

<country 4>

From (dd/mm/yyyy) To (dd/mm/yyyy)

Mode of payment

Once approved, your claim amount will be credited into your bank account. Kindly provide your bank account information. Bank account name has to match claimant's full name.

☐ **Bank transfer**

Name of bank

Account holder's name

Account number

If you would like the settlement amount by cheque, please fill in the following

Payee name

Address

Declaration, authorisation and consent to use personal data

1. I certify that the information provided in this form is true and complete and I have not withheld any material information that could affect this claim.

2. For the purposes of policy administration, which includes the processing and/or investigation of this claim, I hereby:
   a. authorise any person or organisation who has relevant information on this claim, including but not limited to any medical practitioner, health care provider, clinic, hospital, insurance company and/or investigative agency, to release and exchange any and all information (including personal health information) requested by FWD Singapore Pte Ltd and/or its claims service providers;
   b. authorise FWD Singapore Pte Ltd and/or its claim service providers to collect, use, disclose and/or exchange with such persons or organisations referred to in (a) above any and all relevant information (including personal health information); and
   c. confirm that I am authorised to disclose information (including personal health information) about the insured person if this claim is made on his/her behalf.

3. I also give consent for FWD Singapore Pte. Ltd. to collect, use or disclose 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.

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

5. My signature below will signify my consent.

Signature of policyholder/claimant

Name of policyholder/claimant

Relationship with policyholder

Contact number

Email

Section 2: doctor's statement

Patient's name

NRIC/FIN/Passport number

Date of treatment

Diagnosis

Date of diagnosis

If patient is hospitalised, please indicate date of admission and date of discharge

Date of admission

Date of discharge

When did the patient first consult you for this condition?

Was the patient referred to you by any other doctor or specialist?
If yes, please provide name and address of the doctor, date of referral and reason for referral.

Date of referral

Reason for referral

Was the patient ever tested positive for COVID-19 prior to this incident?

Did the patient experience any symptoms such as a persistent cough, fever, raised temperature?
If yes when did the first symptom start?

Was the patient in close contact with any individual who was diagnosed with COVID-19?
If yes, please state their relationship and date that the patient was informed that they had been in close contact.

Was the patient advised by a medical practitioner to perform a swab test?
If yes, when was the swab test performed? Please state why the test was needed.

Was the patient advised to self-isolate due to COVID-19 (including mandatory government orders to remain at home)?
If yes, please state the reason and dates of the quarantine / stay home order period.

To the best of your knowledge, did the patient comply with the quarantine / stay home order?

Did the patient travel in the last 3 months?
If yes, please state the date which the patient returned to Singapore.

Is the patient still under your care?
If yes, please state progress of the treatment.

Signature of Doctor

Name and designation of Doctor

Name and address of clinic/hospital & company stamp