



Liberty Pte Limited
One Raffles Quay #40-01 North Tower
Singapore 048583
Tel: 1800-LIBERTY (542 3789)
UEN | GST Reg. No. 201538069C
libertyinternational.com/sg

Claim Form – Student Medical Insurance

INSTRUCTIONS

Please submit the following documents within 30 days from the date of discharge from hospital.

Documents Checklist:

For hospitalisation in Government/Restructured Hospital

- Duly completed and signed claim form
- A copy of student pass
- All original final hospital bills, doctor's/specialist's bills and receipts
- Inpatient Discharge Summary
- Inpatient Admission Report (if available)
- Day Surgery Admission Report (if available)

For hospitalisation in Private Hospital/Hospital outside Singapore during school-related activities

- Duly completed and signed claim form
- A copy of student pass
- All original final hospital bills, doctor's/specialist's bills and receipts
- Medical Report from attending physician/specialist
- Inpatient Admission Report (if available)
- Day Surgery Admission Report (if available)

Please submit the completed documents to:

Liberty Pte Limited

One Raffles Quay #40-01 North Tower
Singapore 048583
Attn: Claim Dept - Student Medical Insurance

For Claim information and enquiries, please contact:

Ms Christina Chng
Contact No: 9760 2569
Email: christina@enrichadvisory.com

Ms Genna Ang
Contact No: 9671 5922
Email: genna@enrichadvisory.com



Claim Form – Student Medical Insurance

Please complete all sections to facilitate the processing of your application. This form is issued without admission of liability and it must be completed and returned to us immediately, whether or not a claim is made. Any documentary proof or report required by liberty shall be furnished at the expense of Policyholder or Claimant.

Information of Policyholder/Private Education Institution/School

Name of Policyholder: _____	Policy No.: _____
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Information of Claimant/Student

Name of Claimant: _____	Policy No.: _____	
Mailing Address: _____		
Postal Code ()		
NRIC/FIN/Passport No.: _____	Date of Birth: _____	Contact No.: _____
Designation: STUDENT	Course Start Date: _____	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Email: _____		
Are you claiming from any other insurer in respect of this illness/injury? If Yes, please state: Name of Insurance Company: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Policy No.: _____
Is the condition/disability suffered due to:	<input type="checkbox"/> Illness	<input type="checkbox"/> Accident

Details of Illness

If the condition/disability suffered is due to illness, please provide the following:		
i. Diagnosis:	_____	
ii. Date of symptoms started:	_____	
iii. Details of all symptoms and nature of medical condition/disability suffered:	_____	
Did you seek medical treatment prior to being diagnosed with the illness for which you are now claiming? If Yes, please state: Name of Hospital/Clinic/Physician: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mailing Address: _____	Postal Code	()



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Details of Accident

If the condition/disability suffered is due to Accident, please provide the following:

Date of Accident:

Time of Accident:

Place of Accident:

How did the accident happen?

Road-related

Yes

No

Work-related

Yes

No

Others

Yes

No

Describe the Nature of Injuries sustained:

Please enclose a copy of the police report/accident report (if available).

Claim amount payable to:

Policyholder/Private Education Institution/School

Claimant/Student

The policyholder hereby authorises Liberty to make payment to the student's Parent or Guardian.

Reason: Student does not have a Singapore Bank Account. Please provide supporting documents for relationship between student and student's Parent or Guardian.

Payment Details

Please select the claim payment mode.

Direct transfer into Policyholder/Student/Student's Parent or Guardian's bank account.

Please provide supporting documents such as a bank statement (showing Name of Account Holder and Account Number) for verification of payee details.

Full Name (as shown in the bank account):

Nationality:

Name of Singapore Bank:

Singapore Bank Account No.:

I agree to hold Liberty Pte Limited harmless and that it is fully and finally discharged of its obligations once it has made payment to the bank and bank account number given above.

For payment by PayNow

Please provide us with a copy of NRIC/FIN ID for verification purpose. The claim reimbursement can only be made to the Insured/Claimant and will be paid via transfer to your bank account linked by PayNow NRIC/FIN No. by default. Please ensure that you have signed up for PayNow with your bank by linking it to your NRIC/FIN No.

NRIC/FIN No:

UEN:



Claim Form – Student Medical Insurance

PERSONAL DATA PROTECTION

By signing this form, I/we consent to Liberty Pte Limited (“Liberty”) and its authorised service providers, related entities, and partners (collectively, “Appointees”) collecting, using, and disclosing my/our personal data, and any personal data of other individuals provided by me/us, for purposes including: assessing and providing insurance products and services; policy administration, renewals, claims, and payments; compliance, audit, and regulatory reporting; research, analytics, and service improvement; and communication and customer support. I/we confirm that I/we have read and agree to [Liberty’s Privacy Policy](#), which explains how Liberty manages personal data, including cross-border transfers. If I/we provide personal data of other individuals, I/we warrant that I/we have obtained their consent (or consent from their legal representatives, where applicable) for these purposes. I/we understand that I/we may access, correct, or withdraw consent for my/our personal data at any time by contacting Liberty’s Data Protection Officer at privacy.officer.ap@libertymutual.com, subject to legal and contractual obligations.

DECLARATION

- 1) I declare that I have complied with the conditions and warranties (if any) of the Policy and in no manner deliberately caused the said loss or damage or exaggerated the claim or sought unjustly to benefit by any fraud or willful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.

I authorise the release of any medical information necessary to process this claim.

Date

Signature of Claimant

Date

Signature of Policyholder & Company
Stamp



Claim Form – Student Medical Insurance

Medical Information (to be completed by the attending physician)

Name of Patient: _____		NRIC/FIN No.: _____
Date when the patient first consulted you: _____	Prior to the first consultation with you, when did the patient first suffer the symptoms of the condition: _____	
Presenting complaints: _____		
Was the Patient referred by another physician?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please provide details: _____		
Name of Physician & Clinic: _____		Contact No.: _____
Was there any surgery carried out for this condition?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please provide details: _____		
Surgical Operation or Procedure	Date of Operation or Procedure	Surgical ICD Code (For doctor to complete)
Is there any connection between the present condition and any other pre-existing illness or previous accident?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please provide details: _____		
Is the Condition of the Patient:		
Attempted Suicide	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug/Alcohol related	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Genetic or chromosomal disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hereditary or Congenital in nature	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Infertility related	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnancy related	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychological/Mental Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Related to cosmetic treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Self-inflicted injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexually transmitted disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If any of the above is Yes, please provide details: _____		



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Medical Information (to be completed by the attending physician)

Is the Condition of the Patient related to an Accident? If Yes, please provide details of the Accident, whether it is work-related and if police report was made? <hr/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will illness/injury require further follow-up treatment If Yes, please provide details: <hr/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other relevant information: <hr/>		

Please furnish copies of all the reports/investigations results.

I declare that I have in no manner deliberately exaggerated the claim or sought unjustly to benefit by any fraud or willful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.

I authorise the release of any medical information necessary to process this claim

Date

Signature of Physician

Name of Physician:

Contact No.:

Company Stamp:

