## CLAIM FORM



## **IMPORTANT INFORMATION**

Return this form with original invoices to: Bupa Global, Victory House, Trafalgar Place, Brighton, BN1 4FY, UK.

If you have any questions when completing this form, please call us on +44 (0) 1273 323 56

Raffles Health Insurance Pte Ltd ("RHI") (Company Registration Number: 200413569G) is the insurer and Bupa Global, the trading name of Bupa Insurance Services Limited, is the administrator of the RHI international health insurance plans in Singapore.

Please ensure that all sections of the claim form are fully completed. Note that claims payment may be delayed if all sections of the claim form are not completed in full. The form should be returned to us within six months of the initial treatment date. Always enclose the original invoices - photocopies, receipts and credit card vouchers are not acceptable. Please write clearly in black ink and BLOCK CAPITALS.

Please complete a new / separate claim form for: O each patient O each in-patient / day-case stay O each medical condition O each currency

If you have more invoices, you do not need to send a further claim form. Just send the invoices with a covering letter stating the condition and payment instructions. If the condition continues for more than six months, we may request a new claim form to be completed.

We are unable to return original documents, but we will be happy to provide certified copies on request.

This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact your insurer or visit the GIA/LIA or SDIC web-sites (www.gia.org.sq or www.lia.org.sq or www.sdic.org.sq.)

1 PATIENT'S DETAILS															
	Group name (if applicable):														
-															
Title:															
First name:															
Family name:															
Other names:															
Date of birth:	Age last birthday: NRIC N	C No / Passport No:													
Correspondence address:															
Building:															
Street:															
Town / city:															
Area code:															
Region:															
Country:															
Email:															
Telephone:															
Is this your permanent residency address?	Yes	res No													
Do you want all future correspondence sent to the	nis address? Yes	Yes No													
Do you have a residence in the USA?	Yes	Yes No													
In which country did the treatment take place?															
What is the currency of the invoice?															
What is the total amount of the claim?															



2 MEDICAL D	EIAILS (ali	sections must be completed by the	doctor in overall charge of the patient	t's treatment)							
Medical Practitioner's deta	ils:										
Name:											
Address:											
Qualifications:											
Diagnosis:											
Onset date when symptom	s first noticed by patient	D D M M	/   Y								
When did the patient first see a doctor?  DDDMMMYYY  A D D D D D D D D D D D D D D D D D D											
Details of treatment:											
	I										
Details of operation:											
Details of medication:											
Dental treatment											
Annual check		Preve	entive	$\bigcirc$							
Major restorative		Orth	odontics	$\bigcirc$							
Accident / emergency treat	tment	$\bigcirc$									
Details of treatment:											
Hospital dates: Admiss	sion date:	M M Y Y	Discharge date:	D M M Y Y							
Name and address of admi	tting hospital:	Reference number:									
Name:											
Address:											
Telephone:											
Fax:											
Email:				1 [							
Medical practitioner's / de	ntal surgeon's signature			Date							

3 CASH BENEFIT													
The hospital should complete this section if you have stayed in hospital overnight without charge, and your plan includes a Cash Benefit.													
I confirm that													
was in hospital fromand this hospital did not charge for accommo													
The hospital needs to stamp this claim													
4 PAYMENT DETAILS													
	IMPORTANT	INFORMATION											
We can settle claims		cases where we cannot settle in the currency requie currency of your subscriptions.	ested,										
Who would you like us to pay? (please tid	ck one only)												
Doctor / hospital	/ hospital Principal member												
Patient		Group (if on a company plan)											
Please complete either Section A or Se	ection B												
Section A - Payment by cheque													
In which currency would you like us to	pay the cheque? (please ti	ck one only)											
Currency of your invoices Currency of your subscriptions													
Currency of your bank account													
Please specify this:													
Cheques payable to members will be sent by post	to the correspondence address pro	vided on the front page.											
Section B - Payment by Electronic Fund	ds Transfer to a bank accou	int											
Bank name:													
SWIFT / BIC code *:													
Sort code (UK only):													
Account number / IBAN:													
Account name / payee:													
Currency for the transfer:													
Bank address:													

\*In order to process your payment as quickly and securely as possible, we strongly recommend that you provide both your IBAN and the SWIFT code of your bank branch. Your bank will be able to provide you with this information if necessary.

Post / Zip code:

Country:

We recommend that bank transfers are made in the currency of your bank account. If you have asked us to pay the provider, and an annual deductible applies to your cover, the deductible will be collected using your credit card. We will instruct our bank to recharge the administration fee relating to the cost of making the electronic transfer to us, but we cannot guarantee that these charges will always be passed back for us to pay. In the event that your local bank makes a charge for an electronic transfer, we will aim to refund this charge. If we are unable to pay direct to a bank account, or no account details are provided, we will pay by cheque. We reserve the right to send any benefit due to an appropriate person – for example, the executors of the will of someone who has died or the dependant on your membership who has paid the bill.

## 5 YOUR CONSENT TO OBTAIN A MEDICAL REPORT

## **IMPORTANT INFORMATION**

Please read this section carefully, as it sets out your rights under the Singapore Personal Data Protection Act 2012 / Do Not Call Regime and the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (NI) Order 1991.

I understand, acknowledge, agree and consent that:

(a) Raffles Health Insurance Pte. Ltd., Bupa Global, the trading name of Bupa Insurance Services Limited, who is the administrator of international health insurance policies in Singapore and the General Insurance Association of Singapore ("GIA") may/are permitted to collect, use, disclose and/or process my personal data/personal information set out in this form and any other personal information provided by me or possessed by Raffles Health Insurance Pte. Ltd. and Bupa Global (collectively the "Personal Information") and disclose and transfer such Personal Information to reinsurers, lawyers /law firms of Raffles Health Insurance Pte. Ltd. or Bupa Global and 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 investigations relating to the claims;
- (ii) investigating the accident and/or my claims:
- (iii) carrying out and/or dealing with my instructions or responding to any enquiries by me;
- (iv) 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
- (v) complying with applicable law in administering, processing, handling and/or dealing with my claims. (collectively the "Purposes")

Personal Informat (c) my Personal In	b) Reinsurers, lawyers /law firms of Raffles Health Insurance Pte. Ltd. and lawyers /law firms of Bupa Global 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 of Singapore, for one or more of the above Purposes.																																	
Member Name	):																																	
NRIC No / Passport No:																																		
Member's signature:  Contact address: If you do not wish to receive information about products and services, or have any other Data Protection queries pleas.													lease	Date																				
Contact address: If you do not wish to receive information about products and services, or have any other Data Protection queries please write to your administrator's Head of Information Governance, at Bupa House, 15-19 Bloomsbury Way, London WCIA 2BA or at DataProtection@Bupa.com.  6 THIRD PARTY INSURERS																																		
6 THIF  Are some of the										e (fo	or ex	camp	ole, s	tate	insı	urer	or a	n pei	son ,	/ org	anis	atior	n inve	olve	ed in	an	accio	dent	?):					
Yes 1	No	$\bigcirc$																																
Name:																																		
Address:																																		
7 DEC	LA	R	<b>4</b> TI	10	1																													
IMPORTANT INFORMATION - TO BE COMPLETED BY THE PATIENT  I confirm that the information I have given on this form is accurate and correct, to the best of my knowledge. I understand that in the event that terms and conditions of my plan have not been met, RHI and Bupa Global reserve the right to recover any costs directly from the plan holder of myself.  I confirm that I give explicit consent to process my personal information with respect to this claim.  Patient's signature (Parent or guardian if patient is under 16)  Date																																		
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8 PAR	EN	TA	\L/	/Gl	JA	RI	DIA	N	C	1C	ISI	ΞN	<b>T</b> (	to be	con	nplet	ted if	mai	n mei	mber	is ur	der 1	6 yea	rs o	ld)									
Name						<u> </u>	<u> </u>																	<u> </u>					Ļ	Ļ	$\perp$	4		
NRIC/Passport	t No.					Ļ	<u> </u>	L					L										Ļ	1					Ļ	ļ	<u>_</u>	_		
Relationship to	o Mai	n M	emb	er:																					$\perp$				<u></u>		$\perp$	$\perp$		
Signature													Date																					

If you have any queries regarding your claim, log onto our website www.bupa-intl.com/membersworld or contact our customer services team on:

Telephone: +44 (0) 1273 323 563

Fax: +44 (0) 1273 820 517

Email: info@bupa-intl.com

Email is used for your convenience and speed, but we cannot always guarantee the security of this method of communication. You need to be aware that some companies and countries do monitor email traffic. You need to take this into account when choosing to use this method of communication.