Liberty Specialty Markets Singapore Pte. Limited
One Raffles Quay #40-01 North Tower
Singapore 048583
Tel: 1800-LIBERTY (542 3789)
UEN | GST Reg. No. 201538069C
www.libertyinsurance.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 Specialty Markets Singapore 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.:
FUREN INTERNATIONAL SCHOOL PTE. LTD.	SD25M04236 (2026)

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: ☐ Female ☐ Male
Email:		

Are you claiming from any other insurer in respect of this illness/injury? ☐ Yes ☐ No

If Yes, please state:

Name of Insurance Company: Policy No.:

Is the condition/disability suffered due to: ☐ Illness ☐ 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? ☐ Yes ☐ No

If Yes, please state:

Name of Hospital/Clinic/Physician:

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 Specialty Markets Singapore 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

I give consent to Liberty Specialty Markets Singapore Pte. Limited and third-parties including related entities, employees, agents, other insurers, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to myself or other individuals that I have furnished in the past, present & in the future, for one or more of the purposes described in Liberty's Data Protection Policy, including but not limited to considering whether to provide insurance, carrying out due diligence, pricing, administering and servicing my policies, communicating with me, renewals, reinsurance, collections, claims, accounting, audit, legal, compliance, research, analysis, information-sharing, surveys, data storage & backups. I have read and agreed to the full Policy at www.libertyinsurance.com.sg/data-protection-policy/. If there is any personal data relating not to myself but to other individuals that I have furnished in the past, present & in the future, I warrant that I have obtained prior consent from these data subjects (or if they are lacking in legal capacity, from their legal representatives, guardians or parents as the case may be) for Liberty Specialty Markets Singapore Pte. Limited and its Appointees to collect, use and disclose their personal data for the abovementioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform Liberty of any changes to the personal data to my knowledge as soon as practicable.

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? ☐ Yes ☐ No If Yes, please provide details:	
Name of Physician & Clinic: _____	Contact No.: _____
Was there any surgery carried out for this condition? ☐ Yes ☐ 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? If Yes, please provide details: _____	☐ Yes	☐ No
Is the Condition of the Patient:		
Attempted Suicide	☐ Yes	☐ No
Drug/Alcohol related	☐ Yes	☐ No
Genetic or chromosomal disorder	☐ Yes	☐ No
Hereditary or Congenital in nature	☐ Yes	☐ No
Infertility related	☐ Yes	☐ No
Pregnancy related	☐ Yes	☐ No
Psychological/Mental Condition	☐ Yes	☐ No
Related to cosmetic treatment	☐ Yes	☐ No
Self-inflicted injury	☐ Yes	☐ No
Sexually transmitted disease	☐ Yes	☐ No
If any of the above is Yes, please provide details: _____		

Claim Form – Student Medical Insurance

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? _____	☐ Yes	☐ No
Will illness/injury require further follow-up treatment If Yes, please provide details: _____	☐ Yes	☐ No
Any other relevant information: _____		

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: