MYCG & PARTNERS PTE LTD
Co. Reg No. 201803632H
6A Shenton Way, #04-01 OUE Downtown Gallery, Singapore 068815
Tel: +65 8118 6924
Email: customercare@mycg.com.sg
Web: www.mycg.com.sg/ite

ITE CLAIM FORM

Claim Procedure:

1. Complete this follow-up claim form;
2. **Email this form, bills and other documents required under "Document Checklist" on the website to MYCG WITHIN 30 DAYS** of treatment;
3. Keep the original bills for up to one year as the insurer may request of verification or audit;
4. For **GHS claims without LOG, please post this Claim Form and the original Final Hospital Bill to MYCG WITHIN 30 DAYS** of treatment.

I. TYPE OF CLAIM	GPA	GHS (no LOG)	GHS (with LOG)	GHS Pre/Post Bills	Outpatient Mental Health	Outpatient A&E/Specialist (without hospitalisation or surgery)	Outpatient Rider for Clinical Attachment Incidents
Select ✓ One Option	☐	☐	☐	☐	☐	☐	☐

GPA - Group Personal Accident Insurance / **GHS** - Group Hospitalisation & Surgical Insurance / **LOG** - Letter of Guarantee

II. POLICY NUMBER

Type of Student (Full-Time only)	Select ✓ One Option	Intake	Policy Number	Period of Insurance
Local Students (non-Health Science)	☐	January	P1712748	07/01/2019 to 12/01/2020
	☐	April	P1936636	01/04/2019 to 05/04/2020
International Students (non-Health Science)	☐	January	Q0056294 & P1712748	07/01/2019 to 12/01/2020
	☐	April	Q0031287 & P1936636	01/04/2019 to 05/04/2020
Local & International Health Science Students	☐	January	Q0056294 & P1712748	07/01/2019 to 12/01/2020
	☐	April	Q0031287 & P1936636	01/04/2019 to 05/04/2020

A. POLICYHOLDER

Policyholder	**INSTITUTE OF TECHNICAL EDUCATION**

B. CLAIMANT/STUDENT'S PARTICULARS

Full Name (as per NRIC/FIN)			
Correspondence Address			
NRIC/FIN No.		Date of Birth	
Nationality		Gender	☐ Male ☐ Female
Email		Mobile No.	
Student ID		Date of admission to ITE	
Are you a FT / PT Student	☐ Full-Time ☐ Part-Time	Expected graduation date	
Are you on LOA	☐ Yes ☐ No	Start date of LOA	
Reason for LOA	☐ Medical ☐ Non-Medical	End Date of LOA	

C. PAYMENT & BANK ACCOUNT DETAILS (Select ✓ One Option)

☐ **Direct Credit (for Singapore bank accounts only, not applicable for overseas bank accounts)**

Name (as per bank account)			
Bank Name		Bank Code	
Account No.		Branch Code	

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D. ACCIDENT & INJURY DETAILS

Date of Accident		Time of Accident	
Description of Accident			
Description of Injury Sustained (e.g. body part injured, injury type)			
Location of Accident		Is this a work-related injury (e.g. during personal part-time employment but not including official ITE internship, lab work etc.)	☐ Yes ☐ No
Have you injured the same part before? If Yes, please provide details of the previous injury – date occurred, nature of injury/part injured, has the condition fully recovered, date recovered etc.		☐ Yes ☐ No	

E. ILLNESS DETAILS

Diagnosis and/or Symptoms experienced			
Date symptoms first started		Name of doctor/clinic/hospital	
Date of first consultation with a doctor for this condition			

F. OVERSEAS TREATMENT (Please provide proof of travel e.g. boarding pass or passport copy with entry/exit stamp)

Purpose of overseas trip		Was it an official ITE trip?	☐ Yes ☐ No
Date of departure from Singapore		Date of arrival back in Singapore	

G. DEATH / SPECIAL GRANT CLAIM

Date of death		Place of death	
Cause of death			

H. OTHER INFORMATION

Have you claimed or do you intend to claim from any other insurer or parties for reimbursement of your medical bills?	☐ Yes ☐ No
If Yes, please state the name of other insurer/part (Please submit a copy of the settlement letter from the other insurer/party)	

NOTE: It is important that you inform us if you are claiming from another insurer, other employer or any other parties for the same bill. You can only be reimbursed once for the amount that you have incurred regardless of the number of medical insurance policies you may have. We reserve that right to recover if there is any excess amount paid to you.

I. DECLARATION, AUTHORISATION & CUSTOMER'S DATA PRIVACY CONSENT

[Declaration] I/We confirm that I am/We are the claimant and or the Policyholder and I/We declare that all the particulars given above are to the best of my/our knowledge true and correct.
[Authorization] I / We hereby consent to and authorize the medical practitioner involved in the claimant's care to discuss and disclose treatment details and discharge arrangements with and to AXA Insurance. I/We agree that a copy of this consent shall have the validity of the original.
[Customer's Data Privacy Consent] In connection with my/our and/or the claimant's claims, I/We give consent for AXA Insurance ("AXA") and their respective representatives or agents to collect, use, store, transfer and/or disclose the information (including that provided by sources other than myself) concerning me/us and/or the claimant, to or with all such persons (including any member of the AXA Group or any third party service provider, and whether within or outside of Singapore and the Policyholder when claiming under a Group Policy) for the purpose of enabling AXA and their respective representatives or agents to provide me/us and/or the claimant (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/or managing my/our and/or the claimant's claims or the Policyholder Group Policy(ies) with AXA (as the case may be), and for the purposes set out in AXA's Data Use Statement which can be found at http://www.axa.com.sg ("Purposes").

Signature of Student (Parent's or Guardian's signature if Student is a minor i.e. under 21 years old)	**Date**
Remarks	