

Part 1: Details of the Employee / Patient

Name of Employer: Moori Ashok Kumar Reddy	Policy No: G0009376
Name of Employee: Hitachi Vantara	NRIC/Passport No: S7863695E
Date of Birth: 25/07/1978 / yyyy	Nationality: Indian
Marital Status: Married	Plan Type:
Contact No: 81188449	Designation: Capacity Manager
Employee's commencement date of insurance: 01/07/2023 ^{nm} / yyyy	Gender: Male / Female

By default, approved amounts are reimbursed to the Employee. ☐ Please 'tick' this box only if payment (via cheque) is to be made to your Employer.

Please complete this section if Employee is not the Patient

Name of Patient: Bojjireddy Soujanya	NRIC/Passport No: S8477350F	Gender: Male / Female
Relationship to Employee: Spouse	Occupation: IT professional	Date of birth: 25/08/1984 / yyyy

Part 2: Details of the Admission

Text

Date of Admission: 26/03/2024 / yyyy	Date of discharge: 26/03/2024 / yyyy	Name of Hospital / Clinic: K O Chan Ear Nose Throat Sinus&Sleep Centre
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1) If admission is due to sickness, please provide the following:

Diagnosis: Skin and Nose allergy	Symptoms experienced: sneezing, Itchy, Rashes, Skin Allergy, etc.	Date when symptoms first started: 24/03/2024 / yyyy
Has the illness been treated before? No	Date of first treatment: 26/03/2024 / dd / mm / yyyy	
Nature of treatment / operation done: Performed Skin Prick allergy Test to find out the type of allergies and provided Nasal Spray and medication		

2) If admission is due to accident, please provide the following:

Date of accident: / dd / mm / yyyy	Time of accident: hh : mm am / pm	Place of accident:
Briefly describe what had happened and state the extent of the injury:		

3) Are you entitled to claim against Work Injury Compensation Insurance?

- ☐ **No** No, This is not a injury case and its skin allergy issue
- ☐ **Yes** - Please provide further details

4) Are you making a claim from other insurance companies?

- ☐ **No** No, This is the only one claim
- ☐ **Yes** - Please provide Name of the Insurer, Policy Number & submit a copy of the claims settlement letter / payment voucher

Declaration and Authorization (to be signed by the Employee and Patient / Guardian)

I / we, hereby authorize, agree and consent to:

- persons and organizations, whether within or outside Singapore, including but not limited to medical sources, hospitals, doctors, other healthcare professionals, laboratories, regulator, dispute resolution centres and insurers, their associated persons / organizations, my / our or the insured person's employers or financial service providers, or their third party service providers or representatives (collectively "Third Parties") disclosing and releasing to insurer and Fullerton Healthcare Group, its associated persons / organizations, its and their third party service providers and its and their representatives, whether within or outside Singapore any information concerning the policy owner and the insured person(s) at any time, including all personal data and information, medical information, medical history, consultation history and notes, prescriptions, treatments, descriptions of medical services rendered, and any employment and financial information, including the taking of copies of such records (collectively "Personal Data"), relevant for the Purpose (defined below);
- the Insurer and Fullerton Healthcare Group sharing the scope of sub-clause (a) above, along with any of the Personal Data, with any relevant Third Parties to procure their disclosure and release of additional relevant Personal Data for the Purpose;
- the Insurer and Fullerton Healthcare Group, including their approved medical examiners or laboratories, performing any necessary medical assessments and examinations and tests to determine, assess and evaluate the health of the insured person(s)
- the Insurer and Fullerton Healthcare Group collecting, using, disclosing, storing, retaining and / or processing (collectively, "Using" / "Use") the Personal Data for the Purpose; and
- waive any right (on my own behalf and on behalf of the insured person(s) where applicable, in respect of which I / we represent and warrant that the insured person(s) have granted me / us authority to so waive) to bring a claim of any nature against any of the Insurer and Fullerton Healthcare Group in respect of any above-mentioned Use and / or any Use of any Personal Data for the Purpose.

Where I / we are not the insured person, I / we represent and warrant that I / we have obtained the consent of the insured person(s), except to the extent such consent is not required under relevant laws: (i) to collect their Personal Data; (ii) to disclose their Personal Data to the Insurer and Fullerton Healthcare Group; and (iii) for the Insurer and Fullerton Healthcare Group and Third Parties to Use any of their Personal Data in the manner and for the purposes described in this Clause. I / we hereby agree to indemnify Insurer and Fullerton Group for all losses and damages that Insurer and Fullerton Healthcare Group may suffer in the event I / we are in breach of any representation and warranty provided by me / us herein. In this Clause, "Purpose" means any of the purposes described in the Insurer's personal data policies and Fullerton Healthcare Group Data Policy, including but not limited to processing of this form, to provide subsequent advice or services to me / us or the insured person in relation to any existing or future policy / policies / programs that I / we may hold / participate with Insurer and Fullerton Healthcare Group. This authorization shall bind my / our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not my / our Application / form is accepted by Insurer and Fullerton Healthcare Group. A photocopy of this authorization shall be valid and effective as the original.

Disclaimer

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Signature of Employee


Signature of Patient / Guardian (if Patient is a dependent)

11/4/2024

Date