[Child using parent's account]

MINISTRY OF HEALTH
SINGAPORE

MEDICAL CLAIMS AUTHORISATION FORM (SINGLE INSTITUTION)

Central Provident Fund Board Singapore

A - Particulars of Patient

Tick accordingly

Name: Blue Diamond	Date of Birth: (DD-MM-YYYY) 01-01-9999	☐ Singapore Citizen (SC) ☐ Permanent Resident (PR) ☐ Foreigner
NRIC / CPF Account No: TxxxxxxxZ	FIN / Passport No: (for foreigners only)	

B - Particulars of the Additional MediSave Payer

Name: Parent of Blue Diamond	Date of Birth: (DD-MM-YYYY) 02-02-9999	NRIC / CPF Account No: SxxxxxxxJ

The Patient is the Additional MediSave Payer's: ☐ Spouse ☑ Child ☐ Parent ☐ Grandparent (Patient must be SC/PR) ☐ Sibling (Patient must be SC/PR)

C – Purpose

Tick "Y" only if wish to claim from Shield plan

(For the **Patient**) I authorise the Medical Institution to:			(For the **Additional MediSave Payer**) I authorise the Medical Institution to:	
✔	N	Check my healthcare financing coverage;	✔ N	Check my healthcare financing coverage;
Y	N	Withdraw from my MediSave;	✔ N	Withdraw from my MediSave;
Y	N	Claim from my Health Insurance Policy;		

for the Patient's treatment charges incurred at: Name of the **Medical Institution:** KK Women's and Children's Hospital

✔	N	for hospitalisation[1] / day surgery / treatment period starting on / from:	Date: (DD-MM-YYYY) 31-12-9999
Y	N	for all outpatient treatments	

(a) claimable under

Y	N	Renal dialysis	Y	N	Flexi-MediSave	Y	N	Cancer scans
Y	N	Chemotherapy	Y	N	Radiotherapy	Y	N	Anti-Retroviral Drugs
Y	N	Outpatient scans	Y	N	Approved chronic diseases, vaccinations, screenings			
Y	N	Other schemes (please specify):						

(b) and sought

Y	N	on:	Date: (DD-MM-YYYY)		
Y	N	within the limited period[2] from:	Date: (DD-MM-YYYY)	to	Date: (DD-MM-YYYY)
Y	N	for an indefinite period[2], until revoked in writing, starting from:			Date: (DD-MM-YYYY)

1: If the Patient authorises use of MediSave and passes away during this hospitalisation, the Patient's MediSave balance will be used to pay the last hospitalisation bill first before any withdrawal can be made from the MediSave Account of any Additional MediSave Payer(s).
2: Please inform the staff at the Medical Institution during your visit how you would like the bill to be claimed. If you do not do so, the Medical Institution may, as authorised, claim the bill in full from the Patient's and/or the Additional MediSave Payer's MediSave and Health Insurance Policy.

D - Authorisation on Behalf of Patient / Additional MediSave Payer

(Please complete this part only if you are signing on behalf of the Patient or the Additional MediSave Payer.)

Name: Parent of Blue Diamond	Date of Birth: (DD-MM-YYYY) 02.02.9999	NRIC / FIN / Passport Number: SxxxxxxxJ

I am signing this form on behalf of (please tick):

☑ **the Patient**, because:
- ☑ I am the parent / legal guardian[3] of the Patient who is under 21 years of age.
- ☐ he/she lacks capacity[4], and I am his/her:
  - ☐ donee / deputy[5].
  - ☐ family member[6].
- ☐ he/she is deceased, and I am his/her:
  - ☐ donee / deputy[5].
  - ☐ family member[6].

☐ **the Additional MediSave Payer**, because:
- ☐ I am the parent / legal guardian[3] of the Additional MediSave Payer who is under 21 years of age.

3: You are lawfully appointed as a legal guardian by a court or under a will/deed.
4: A person lacks capacity as set out in Section 4 of the Mental Capacity Act (Cap. 177A) ("**MCA**").
5: You are acting under a Lasting Power of Attorney registered under the MCA with power to act on behalf of the Patient, or are appointed by the Court under the MCA to act on behalf of the Patient.
6: You are the spouse, child, or parent of the Patient, are 21 years old and above, and do not lack capacity.

(The section below must be completed by a doctor if the Patient lacks capacity and a doctor's certification or court order has not already been obtained.)

Doctor's Certification

I certify that the Patient lacks capacity and is unable to sign this form.

Name of Doctor:	Doctor's MCR:	Clinic / Hospital Stamp:
Doctor's Signature:	Date of Signature (DD-MM-YYYY):	

Consent to Data-Sharing & Use of Information

1. I allow the Government of the Republic of Singapore and its appointed agencies, the Central Provident Fund Board ("**CPF Board**"), my Insurer and its appointed agencies, the Medical Institution, and healthcare professionals at any medical institution who have cared for the Patient ("**the Parties**"), as applicable, to collect, share and use my Information (a) to facilitate the Patient's treatment, (b) for the purposes I indicated in Part C, and (c) for data analysis, evaluation, and policy-making and review by the Government and CPF Board.
2. If I have also applied to withdraw from my MediSave or claim from my Health Insurance Policy in Part C, I agree to provide any information necessary to any of the Parties in paragraph 1 to process and administer the Claims. I further understand and agree that my Information may be collected, shared and used by any of the Parties to process and administer the Claims resulting from the Patient's treatment charges, to assess and audit the Claims, and adjudicate Claims-related disputes.

Claim Authorisation

3. If I have applied to withdraw from my MediSave or claim from my Health Insurance Policy to pay for the Patient's treatment charges at the Medical Institution for the treatments indicated in Part C:
   a) I authorise CPF Board and my Insurer to do all things necessary to process and administer the Claims;
   b) I accept that the Claims will be subject to CPF Board's and my Insurer's approval, and the approved Claims amounts will depend on (i) the treatment charges submitted by the Medical Institution, (ii) my MediSave balance, (iii) the relevant Acts & Regulations, and (iv) the terms of my Health Insurance Policy, if applicable; and
4. I agree to immediately refund to my MediSave Account and my Insurer any payment which I receive as reimbursement for the treatment charges.
5. I agree that this authorisation will be valid for claims submitted (i) within 12 months after the date of signature, (ii) within 12 months after the end date indicated in Part C (for authorisations for a limited period), or (iii) by the revocation date (for authorisations for an indefinite period), whichever is later. I acknowledge that I may have to provide further authorisation if any Claims are submitted by the Medical Institution after this authorisation expires.

General

6. I have read and understood this form fully, including the Definitions below, and I declare that the information that I have provided is accurate.

Signature / Thumbprint of Patient / Person signing on behalf of Patient	Signature / Thumbprint of Additional MediSave Payer / Person signing on behalf of the Additional MediSave Payer	Signature of Witness & Date of Signature
Parent's signature	Parent's signature	
Date of Signature (DD-MM-YYYY): 31-12-9999	Date of Signature (DD-MM-YYYY): 31-12-9999	Name of Witness:
Interpreted by (Name & NRIC):	Interpreted by (Name & NRIC):	NRIC / Official Stamp:

Definitions

I understand and agree that these phrases used in this form shall have the following meanings:

a) **"Information"** refers to the following information in relation to both the Patient and the Additional MediSave Payer:
   i) personal data (e.g. name, NRIC No, address, age, date of birth);
   ii) MediSave balance and withdrawal limits;
   iii) any other administrative information as the Government and its appointed agencies, CPF Board, the Insurer and its appointed agencies, the Medical Institution, and healthcare professionals at any medical institution who have cared for the Patient may consider necessary for the purpose of processing, administering, assessing, and auditing the Claim;

   and additionally the following healthcare information in relation to the Patient only:
   iv) hospitalisation and bill records;
   v) medical information and information relating to the Patient's medical condition and treatment; and
   vi) Health Insurance Policy information (e.g. policy details, benefits, exclusions, start and end dates);

   For the avoidance of doubt, "Information" may relate to information on both past and present matters.

b) **"Health Insurance Policy"** and the corresponding **"Insurer"** refer to the following:

Health Insurance Policy	Insurer		
MediShield & MediShield Life	Central Provident Fund Board		
MediSave-approved Integrated Shield Plan*	Income Insurance Limited	AIA Singapore Private Limited	Prudential Assurance Co
	Singapore Life Ltd.	Great Eastern Life Assurance Co	HSBC Life (Singapore) Pte. Ltd.
	Raffles Health Insurance	Any other insurer as approved by the Minister of Health	

* MediSave-approved Integrated Shield Plan refers to the MediSave-approved integrated medical insurance plan as stated in the Central Provident Fund (MediShield Scheme) Regulations and the Central Provident Fund (Private Medical Insurance Scheme) Regulations, and the attached rider plans.

c) **"Claims"** refers to all claims from the Health Insurance Policy or all withdrawals from MediSave, as authorised in Part C.

d) **"Acts & Regulations"** refers to all relevant legislation governing the use of MediSave, MediShield and MediShield Life, including the Central Provident Fund Act, Central Provident Fund (Medisave Account Withdrawals) Regulations, Central Provident Fund (MediShield Scheme) Regulations, Central Provident Fund (Private Medical Insurance Scheme) Regulations, and the MediShield Life Scheme Act 2015 and its regulations, and any amendments or re-enactments thereof.