## **CP01 – Mediclaim Online Portal New User Account Application Form**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **To be completed by New User (Fax/Email form as specified below)** | | | | |
| **Application** | **Method** | **Email** | | **Attn:** |
| MediClaim Portal | Email | [mediclaim\_admin@moh.gov.sg](mailto:mediclaim_admin@moh.gov.sg) | | MediClaim Admin |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | NRIC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Contact No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Clinic Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  HCI Code *(Refer to clinic license number) :*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hospital Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| UEN / Entity ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  | | | | |
| **Undertaking to Safeguard Information and Declaration of Security**  I understand and agree to the following:  1. The data required will only be used for the purpose specified.  2. No data will be disclosed to a third party without prior authorization from the Ministry of Health.  3. All necessary measures and precautions will be taken to protect the security and privacy of data.  4. To avoid unauthorized access, to report loss of Onekey within 24 hours. | | | | |
| Applicant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: :\_\_\_\_\_\_\_\_\_\_\_\_\_ | |