Mailing Address : 43 Hindhede Walk #07-08 Singapore 587973
Email Address : contact@rdss.org.sg
Contact No : 6402 2898
Website : www.rdss.org.sg

APPLICATION FORM FOR OPTICAL / DENTAL SUBSIDY

Collate up to $480 worth of invoices with proof of payment within one financial year (Invoices dated 01 June - 30 April) for each of the category.
You can submit your claims twice a year with these cut off dates : **30 November & 30 April**

SECTION A : APPLICANT'S PARTICULARS (must be a registered RDSS Beneficiary)

BENEFICIARY NAME (underline surname) : ______________________________

____

DATE OF BIRTH (DD/MM/YYYY) : _____/_____/___________ AGE : ________ IDENTIFICATION NO : T / S X X X X ___ ___ ___ ___

GENDER : FEMALE / MALE RACE : ______________________ NATIONALITY : SINGAPORE / PERMENANT RESIDENT

NAME OF PARENT APPLYING ON BEHALF (underline surname) : ______________________________

RELATIONSHIP TO THE BENEFICIARY : FATHER / MOTHER / GUARDIAN ______________________________

MOBILE NO : ______________________ EMAIL ADDRESS : ______________________________

RESIDENTIAL ADDRESS :

BLK / NO : ________________ UNIT NO : ________________ POSTAL CODE : ____________________

STREET : ______________________________

SPOKEN LANGUAGE(S) : ______________________ WRITTEN LANGUAGE(S) : ______________________

APPLICANT'S MEDICAL CONDITION AND TYPE OF SUBSIDY CLAIMING FOR

MAIN MEDICAL DIAGNOSIS : ______________________________

NATURE OF SUPPORT : ☐ PERMENANT ☐ TEMPORARY

NATURE OF DISABILITY (if any) : ☐ PERMENANT ☐ TEMPORARY -> DURATION OF DISABILTY : ________ (MONTH)

TYPE OF SUBSIDY CLAIMING FOR : ☐ DENTAL ☐ OPTICAL

SECTION B : ASSESSOR ENDORSEMENT

(ONLY MEDICAL DOCTOR, (MEDICAL) SOCIAL WORKER, HOMECARE / PALLIATIVE NURSING PERSONNEL CAN ENDORSE)

I confirm that the assessment done for the above applicant is true and correct to my best knowledge. I am aware that the assessment for this application will serve as reference only. Rare Disorders Society (Singapore) reserves the right to make the final decision on the application outcome and reject any application if the information is found to be inaccurate, or if any relevant information has been withheld by applicant.

ASSESSOR NAME : ______________________ HEALTH INSTITUTION : ______________________

DESIGNATION : ______________________ EMAIL ADDRESS : ______________________

CONTACT NO : ______________________

______________________	______________________	______________________
SIGNATURE	ORGANISATION NAME AND STAMP	DATE

Mailing Address : 43 Hindhede Walk #07-08 Singapore 587973
Subsidy Forms Mailing Address : 267C Punggol Field #12-127 Singapore 823267
Email Address : contact@rdss.org.sg
Contact No : 6402 2898
Website : www.rdss.org.sg

RARE DISORDERS SOCIETY (SINGAPORE)
REIMBURSEMENT FORM FOR OPTICAL / DENTAL SUBSIDY

BENEFICIARY NAME (underline surname) : ____________________

ITEM NO	OPTICAL OR DENTAL	INVOICE NO	AMOUNT
1			
2			
3			
4			
5			
6			
7			
8			
		TOTAL :	

PLEASE SELECT YOUR PREFERRED REIMBURSEMENT MODE.

☐ BY PAYNOW (MOBILE NO THAT IS REGISTERED TO YOUR PAYNOW) : ____________________

☐ BY CHEQUE, PAYABLE TO PAYEE NAME (NAME AS PER BANK RECORDS) : ____________________

PLEASE HELP TO MAIL THE CHEQUE TO :

BLK / NO : ____________ UNIT NO : ____________ POSTAL CODE : ____________

STREET : ____________________

NOTE :

(1) Reimbursement(s) can only be made payable to either parent of the beneficiary or the beneficiary himself/herself.

(2) Original application form, with supporting documents must be mailed to RDSS in order to receive the reimbursement.

(3) If you provide any information that is untrue, inaccurate, outdated or incomplete, or if RDSS have any reasonable grounds to suspect so, we reserved the right to reject or cancel your application and/or refuse any current or future application(s) for financial reimbursement(s).

(4) Latest date that RDSS has to receive the application form with the supporting documents : **15 DEC & 30 APRIL**

(5) Refer to the FAQ for more information about the OPTICAL / DENTAL SUBSIDY.

NAME OF PARENT APPLYING ON BEHALF FOR BENEFICIARY : ____________________

SIGNATURE : ____________ **DATE :** ____________

FOR RDSS INTERNAL USE ONLY (YOUR NAME AND SIGN OFF)	
CHECKED BY : ____________ DATE :	APPROVED BY : ____________ DATE :