



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

Collate up to \$480 (for each financial year) worth of invoices with proof of payment, for each of the category.
You can submit your claims twice a year with these cut off dates : **15 December and 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.

ASSESOR NAME : _____ HEALTH INSTITUION : _____

DESIGNATION : _____ EMAIL ADDRESS : _____

CONTACT NO : _____

_____ SIGNATURE _____ ORGANISATION NAME AND STAMP _____ DATE



RARE
DISORDERS SOCIETY
SINGAPORE

Mailing Address : Bedok Central Post Office PO Box 631 Singapore 914608
Email Address : contact@rdss.org.sg
Contact No : 8088 9294
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 :

RESIDENTIAL ADDRESS

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 (YOUR NAME AND SIGN OFF)	
CHECKED BY : _____ DATE : _____	APPROVED BY : _____ DATE : _____