



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

Closing date: **30 April (Refer to Financial Schemes Guide for more details)**

For each financial year, you can submit up to \$600 worth of invoices (with proof of payment) for each category.

**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 / PERMANENT 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 : ☐ PERMANENT ☐ TEMPORARY

NATURE OF DISABILITY (if any) : ☐ PERMANENT ☐ TEMPORARY -> DURATION OF DISABILITY : \_\_\_\_\_ (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



**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) : \_\_\_\_\_

REGISTERED PAYNOW NAME : \_\_\_\_\_

☐ BY BANK TRANSFER (BANK NAME & ACCOUNT NO.) : \_\_\_\_\_

BANK ACCOUNT HOLDER NAME: \_\_\_\_\_

**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 : **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 : \_\_\_\_\_