



RARE DISORDERS SOCIETY SINGAPORE

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

Closing date: **30 November (Refer to Financial Schemes Guide for more details)**
 The claim cap is temporary set to \$900 for Year 2026 (for invoices dated 1 June 2025 to 30 Nov 2026) for each category
Self Applicant must be 21 years old and above

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

MOBILE NO : _____ EMAIL ADDRESS : _____

RESIDENTIAL ADDRESS

BLK / NO : _____ UNIT NO : _____ POSTAL CODE : _____

STREET : _____

If applying the scheme on behalf of beneficiary, please fill up the following:

RELATIONSHIP TO THE BENEFICIARY : FATHER / MOTHER / GUARDIAN / SPOUSE

NAME OF PERSON SUBMITTING THE FORM (underline surname) : _____

MOBILE NO : _____ EMAIL ADDRESS : _____

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 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.

ASSESOR NAME : _____ HEALTH INSTITUION : _____

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 November**
- (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 : _____