



AIA SINGAPORE GROUP HOSPITAL & SURGICAL CLAIM FORM

Corporate Solutions

3 Tampines Grande, #07-00, AIA Tampines, Singapore 528799, Fax: 6538 5603 / 6538 4340, Email : sg.eb.claims@aia.com

CLAIM PROCEDURES

FOR PRIVATE HOSPITAL INPATIENT CLAIMS

Please assist to submit the following :-

- a) Duly completed Section 1 of the Claim Form.
- b) Duly completed Section 2 of the Claim Form by the Attending Physician / Surgeon.
- c) All original Final Summary and Detailed Hospital Bill including Pre & Post Hospitalisation tax invoices.
- d) Other additional supporting document (if any) on the medical condition that can assist in the assessment of the claim :-
 - Referral Letter from General Practitioner (GP) to Specialist / Hospital
 - Any referral form for laboratory / blood test
 - Histology Report

FOR GOVERNMENT / RESTRUCTURED HOSPITAL INPATIENT CLAIMS

Please assist to submit the following :-

- a) Duly completed Section 1 of the Claim Form.
- b) All original Final and Detailed Hospital Bill including Pre & Post Hospitalisation tax invoices.
- c) Other additional supporting document (if any) on the medical condition that can assist in the assessment of the claim :-
 - Copy of Ambulatory Form / Pre Admission Form
 - Copy of Inpatient Discharge Summary
 - Referral Letter from General Practitioner (GP) to Specialist / Hospital
 - Any referral form for laboratory / blood test
 - Histology Report
- d) If the incurred hospital bill amount exceeds S\$1,000/-, the claimant will have to submit the Section 2 of the claim form to the Medical Records Department of the hospital for the completion by the attending Physician. AIA will reimburse up to *S\$80/- subject to the maximum of "Other Services" benefit as stated in the policy schedule or the benefit amount stipulated in the specific policy provided the claim is payable.

Important Notes :

1. The claimant is required to submit the claims document within 20 days of discharge from the hospital.
2. To enable the claim to be processed on a timely basis, please duly complete all the questions in the claim form and attach all the required documents.
3. The claim will be returned if the required documents are not provided together with this form.
4. * The reimbursable amount of S\$80/- is subject to AIA's review and may change accordingly.



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Section 1 : Claimant's Statement

Part A : To be completed by Employee & Dependant (if is a dependant's claim)

Company Name (Policyholder) :				Policy No :	
1) Name of Employee			NRIC / Passport No.		Date of Birth (DD/MM/YY)
Occupation	Date of Employment (DD/MM/YY)	Employee ID / No.	Plan Type	Gender Female <input type="checkbox"/> Male <input type="checkbox"/>	
Contact No.		Email Address			
2) Name of Patient (if patient is dependant)			NRIC / Passport No.		Date of Birth (DD/MM/YY)
Occupation		Relationship to Employee Spouse <input type="checkbox"/> Child <input type="checkbox"/>		Gender Female <input type="checkbox"/> Male <input type="checkbox"/>	

Part B : Details of Illness / Accident

1) Nature of Illness / Final Diagnosis		Symptoms Experienced		Date Symptoms First Started (DD/MM/YY)	
Date First Treated (DD/MM/YY)	Date of Admission (DD/MM/YY)	Date of Discharge (DD/MM/YY)	Nature of Treatment / Operation Done		
2) Accident : Date (DD/MM/YY) & Time (HH/MM)		Describe How Accident Happened & Nature of Injury			
3) Are you claiming from other insurers? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, insurer's name:		Policy No.	

Part C : Claims Payment Details (If is via GIRO, the bank details provided herein has to be Employee's bank account)

<input type="checkbox"/>	Bank Name	Branch Code	Bank A/C No.
<input type="checkbox"/>	Cheque : <input type="checkbox"/> Employer <input type="checkbox"/> Employee		Name :

Part D : Declaration and Authorisation

(This part must be signed by the patient or patient's parent / legal guardian if the patient is below 21 years of age)

a) I/We hereby authorize, agree and consent to AIA Singapore to request from any hospital, physician, person or organization, all information with respect to any illness, injury, medical history, and copies of all hospital or medical records concerning myself at any time and authorize the prior mentioned organizations to disclose all such information to AIA Singapore.

b) I/We consent to AIA Singapore, its associated persons/organisations, third party service providers and representatives, whether within or outside Singapore (collectively "AIA Persons") to collect, use, disclose, store, retain and/or process (collectively, "Use") all personal data and information ("Personal Data") provided to AIA Persons or that they possess about me/us, in the manner and for the purposes described in the AIA Personal Data Policy ("PD Policy") which is available on AIA Singapore's website.

I/We agree to accept the provisions in the PD Policy as amended from time to time. Where Personal Data of another person is disclosed by me/us, I/we confirm that I/we have obtained the consent of the individual concerned, except to the extent such consent is not required under relevant laws to collect, use and/or disclose such Personal Data. I/We waive (on my/our own behalf and on behalf of each such other person) any right to claim against any of the AIA Persons for any Use in the nature of or for the purposes described above or in the PD Policy. I/We will indemnify AIA Persons for all losses and damages if I/we breach these provisions.

c) This consent shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not our Application/form is accepted by AIA Singapore. A photocopy of this consent shall be valid and effective as the original.

Signature of Employee

Signature of Patient (if is a dependant)

Date (DD/MM/YY)

Part E : To Be Completed by Employer

Signature of Employer

Company's Name & Stamp

Date (DD/MM/YY)





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Section 2 : Medical Report

To be completed by Attending Physician

For Admission to Private Hospital or Hospital outside Singapore, patient must arrange to have this section completed by the Attending Physician when submitting a claim.

Company Name (Policyholder) :		Policy No :																				
1) Name of Patient		NRIC / Passport No.																				
2) Final Diagnosis of illness or extent of injury	ICD Code	ICD Code	ICD Code																			
	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table>							<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table>							<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table>							
3) What is the cause of illness / injury?		4) Please specify the approximate date of discovery of the illness or injury																				
5) How long has the illness / injury been existing prior to consulting you?		6) Did the patient have any symptoms prior to consulting you? <input type="checkbox"/> Yes <input type="checkbox"/> No - If "Yes", please indicate the nature of Symptoms and date Symptoms first started:																				
7) When did the patient first consult you for this condition?		8) Nature and Date of Treatment rendered																				
9) Has the patient ever had the same or similar condition / symptom? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not to my knowledge If "Yes", please indicate when and describe																						
10) Has the patient had any prior treatment for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not to my knowledge If "Yes", please state the following :- <table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border-bottom: 1px solid black; text-align: center;"><u>Name of Doctor</u></td> <td style="width: 20%; border-bottom: 1px solid black; text-align: center;"><u>First Consultation Date</u></td> <td style="width: 30%; border-bottom: 1px solid black; text-align: center;"><u>Name of Clinic</u></td> <td colspan="2" style="width: 20%; border-bottom: 1px solid black; text-align: center;"><u>Address</u></td> </tr> </table>					<u>Name of Doctor</u>	<u>First Consultation Date</u>	<u>Name of Clinic</u>	<u>Address</u>														
<u>Name of Doctor</u>	<u>First Consultation Date</u>	<u>Name of Clinic</u>	<u>Address</u>																			
11) Admission Period		12) Name of Hospital																				
13) Date of surgical procedures or treatment rendered		14) If excision was performed, please indicate the size of the lesion / tumor. Please attach a copy of the histology report.																				
15) Describe the surgical procedures or treatment rendered. If no surgery was performed, please state treatment / medication given.		Operation Code	Operation Table																			
	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table>							<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table>														
16) Were the above surgical procedures approached through the same incision / orifice? <input type="checkbox"/> Yes <input type="checkbox"/> No		17) Was the surgery performed for cosmetic purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
18) Is the condition / treatment related to : a) Congenital Anomaly / Genetic / Chromosomal Disorder b) Psychological / Mental / Emotional Disorder c) Dental / Gum Treatment / Oral Mucosal d) Pregnancy / Childbirth / Infertility / Sub-fertility Condition e) Self-inflicted Injury / Drug Addition / Alcoholism		Yes	If "Yes", please elaborate	No																		
		a) <table border="1" style="width: 40px; height: 20px;"></table>		<table border="1" style="width: 40px; height: 20px;"></table>																		
		b) <table border="1" style="width: 40px; height: 20px;"></table>		<table border="1" style="width: 40px; height: 20px;"></table>																		
		c) <table border="1" style="width: 40px; height: 20px;"></table>		<table border="1" style="width: 40px; height: 20px;"></table>																		
		d) <table border="1" style="width: 40px; height: 20px;"></table>		<table border="1" style="width: 40px; height: 20px;"></table>																		
19) Is the patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No - If "No" please give date service was terminated and furnished name and address of doctor if the patient has been referred to another doctor for follow-up.																						

Signature of Physician / Surgeon	Date (DD/MM/YY)
Name / Designation	Name and Address of Clinic / Hospital & Stamp