AIA SINGAPORE
OUTPATIENT CLAIM FORM

Corporate Solutions
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IHS / Clinical / Specialist

1. **This form is for filing of claims for :-**
   - **Treatment at Government Polyclinics**
   - **Specialist Outpatient Treatment (if applicable) with referral letter from a registered general practitioner**
   - **Treatment at Non-panel Clinics**
2. **Claims should be submitted within 20 days with original bills and tax invoices. Original bills and tax invoices must show the patient's name, date of treatment's, diagnosis and must have the attending physician's stamp and signature.**
3. **Claims for Specialist Outpatient Treatment or X-rays / Laboratory test must include a copy of the attending physician referral letter.**
4. **Claims for purchase of drugs must include a copy of the attending physician's prescription.**

Type of Claim (Please tick ✓) – Applicable only if the Policy has the following benefits

IHS General Practitioner		**AIA Specialist Outpatient Plan**
☐ Treatment at Non-panel GP Clinic	☐ Emergency Outpatient Treatment	☐ Specialist Outpatient Treatment
☐ Treatment at Polyclinic	☐ Overseas Outpatient Treatment	☐ Specialist Outpatient Treatment (Pre / Post Hospitalisation)

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 ☐ Male ☐
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 ☐ Child ☐		Gender Female ☐ Male ☐

Part B : Details of Illness

Date of Consultation (DD/MM/YY)	Final Diagnosis	Amount Incurred

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

☐	Bank Name		Branch Code				Bank A/C No.												
☐	Cheque : ☐ Employer ☐ 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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