HOSPITAL FORM For ADMISSION

AA INTERNATIONAL

Policy No.:

Patient name (as stated in Membership Card)**:**

NRIC / Passport No. / Birth Cert. No.: **Age:**

--- 24 HOURS HOTLINES ---

6323 8388
or Fax to:
6235 0739

Patient's section below:

A. AUTHORIZATION

(i) I hereby authorise any hospital, physician or any person who will be attending/has attended to me to provide and medical report concerning myself, including but not limited to my personal information, past medical history, psychological notes, medical information, medical statement, test results, medical images, biological images, laboratory reports and radiology reports, whether in written form, electronic form, graphical form or any other form as it may exist (hereinafter referred as "Information") to ASSISTANCE ALLIANCE INTERNATIONAL (SINGAPORE) PTE. LTD. (hereinafter refers to as "AAIS"), addressed at 123 PENANG ROAD #06-13 REGENCY HOUSE SINGAPORE 238465, including its associate companies and affiliates, as may be required in connection with my health or medical or travel insurance coverage or third party administration programme.

(ii) I further authorise AAIS, including its associate companies and affiliates to have access, to use and to receive such Information from the above-named party for the purpose of providing healthcare benefits administration services which includes evaluation and utilisation review of healthcare services rendered as well as to coordinate, assess and determine my entitlements, benefits and/or reimbursements in connection with my health, medical or travel insurance coverage or third party administration programme.

(iii) I further authorise AAIS to disclose and furnish the Information within the AAIS group or to service providers that are performing services for AAIS or acting as AAIS's agents, the relevant insurance companies, medical practitioners, health care providers who may be involved in my treatment directly or indirectly, and/or arrangement for my evacuation or repatriation (if required) and the relevant governmental authorities, agencies or institutions where required by law or for legal purposes. The Information may be transferred outside Singapore to a country that provides similar protections to the Personal Data Protection Act 2012 for Singapore. AAIS will ensure that any such service providers will comply with all laws relating to privacy and confidentiality of the Information and use it only for the purposes for which Information is transferred and use in accordance with AAIS's directions.

B. DURATION

I understand this authorisation will remain effective and from the signing date hereof for a reasonable period in accordance with legal requirements and for administration purposes for so long as the purpose as hereinabove specified remains valid and in operation.

C.NOTICE OF RIGHTS

I understand I have a right to obtain a copy of this authorisation by written request to AAIS. An original as well as a duplicate copy of this Authorisation authorises the disclosure of the information I have authorised to be disclosed.

I reserve the right to access to or amend or to correct my Information that is inaccurate, incomplete, misleading or not-up-to-date or to delete my Information which is in the possession or under the control of AAIS, subject to the relevant provisions and exemptions under the Singapore Personal Data Protection Act 2012.

(Note: Please send your request by providing your name, date of birth and unique identifiers (identity card number, passport number, policy number).Send this information to compliance@aa-international.com.sg. Please quote 'Data Protection Request' as the email subject.)

D. UNDERTAKING

I undertake to settle directly with the hospitals and medical service providers all medical expenses incurred in connection with my treatment in the event that my insurance policy is not engaged, not applicable or not in effect (notwithstanding any initial confirmation of cover by AAIS or my insurer). I further undertake to reimburse AAI Singapore or my insurer in full together with any costs and expenses that may be incurred and which have been paid on my behalf.

I have had full opportunity to read and consider the contents of this authorisation, and I understand that, by signing this for, I am confirming my authorisation of the use and/ or disclosure of my protected health information, as described on this document. I declare and acknowledge that all information in this form are true, accurate and free from any material omission.

If I sign this form as the Patient's Legal Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

Patient signature: Date:

Mobile Phone Contact No.: