AIA SINGAPORE
GROUP HOSPITAL & SURGICAL CLAIM FORM

Corporate Solutions
3 Tampines Grande, #07-00, AIA Tampines, Singapore 528799 .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 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 90 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 / FIN / 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 / FIN / Passport No.	Date of Birth (DD/MM/YY)
Occupation		Relationship to Employee Spouse ☐ Child ☐		Gender Female ☐ Male ☐

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 ☐ No ☐		If yes, insurer's name:	Policy No.

Part C : Claims Payment Details (Please ensure that the bank details provided is the Employee's bank account)
Note: Payment will be made to employee only, unless prior arrangement was made by your employer with AIA Singapore

Bank Name		Branch Code				Bank A/C No.												

☐ Please tick here if payment is to be made to **Employer. DO NOT key in any bank information in above.**

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 / FIN / Passport No.

2) Final Diagnosis of illness or extent of injury

ICD Code | ICD Code | ICD Code

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?
❒ Yes ❒ 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? ❒ Yes ❒ No ❒ Not to my knowledge
If "Yes", please indicate when and describe

10) Has the patient had any prior treatment for this condition? ❒ Yes ❒ No ❒ Not to my knowledge
If "Yes", please state the following :-

Name of Doctor	First Consultation Date	Name of Clinic	Address

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

16) Were the above surgical procedures approached through the same incision / orifice? ❒ Yes ❒ No

17) Was the surgery performed for cosmetic purposes?
❒ Yes ❒ No

18) Is the condition / treatment related to :

	Yes	If "Yes", please elaborate	No
a) Congenital Anomaly / Genetic / Chromosomal Disorder	a)		
b) Psychological / Mental / Emotional Disorder	b)		
c) Dental / Gum Treatment / Oral Mucosal	c)		
d) Pregnancy / Childbirth / Infertility / Sub-fertility Condition	d)		
e) Self-inflicted Injury / Drug Addiction / Alcoholism	e)		

19) Is the patient still under your care for this condition? ❒ Yes ❒ 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