AIA SINGAPORE
AIA ASSIST / AROUND THE WORLD CLAIM FORM

Policy Number: _____

This printed form is forwarded on receipt of notice of a claim and its being sent is in no way an admission of claims.

PART 1 (TO BE COMPLETED BY POLICYOWNER)

CLAIMANT'S PARTICULARS

Name of Insured Person:	NRIC/FIN/Passport No:	Name of Policyowner:
Home Address:	Age: Sex: ❒ Male ❒ Female	Relationship to Insured Person:
Occupation:	Name of Employer:	Nature of Business:

GENERAL INFORMATION

Place, Date and Time where event occurred:

Describe the event in detail (in the case of sudden and unexpected sickness, state also the symptoms experienced and its duration. In the case of an accidental injury, state also the nature and extent of injuries sustained).

Travel Agent and/or Airline Company:

Departure Date of Insured Journey: Arrival Date of Insured Journey:

Are there any other insurance policies covering the insured person in respect of this event? ❒ Yes ❒ No
If yes, please give names of insurers, policy numbers and amount recovered or recoverable:

Basic Documents Required: (a) Travel ticket/Boarding Pass (b) Copy of relevant parts of your passport and any other documents that we may require.

Please complete the relevant benefit(s) that you are claiming:

PERSONAL ACCIDENT (ACCIDENTAL DEATH & PERMANENT DISABILITY)

In the case of an accidental death, what is the official cause of death?

In the case of an accidental injury resulting in permanent disablement, has the insured person suffered this or similar condition or a recurrence of a previous injury?

❒ Yes ❒ No If Yes, please specify:

Date of previous injury: Insurance Co.s Involved:

Amount Claimed: Circumstances:

Name(s) and Address(es) of doctor(s) who attended to insured person

Is the insured entitled to receive compensation from any other source in respect of this accident?

❒ Yes ❒ No If Yes, please specify:

Source of Compensation: Amount Compensated:

Documents Required: (a) Medical Report (b) Police investigation report (c) Newspaper report (if any). In the case of an accidental death, please also submit a Certified True Copy of the death certificate.

REPATRIATION / EMERGENCY MEDICAL EVACUATION BENEFITS

Has the insured person contacted AIAS for assistance? ❒ Yes ❒ No If 'No', please provide reason(s):

Was the sen/ice approved and arranged by AIAS? ❒ Yes ❒ No

Exclusion No.6 & 7 applicable to section 4 (Part III & IV):

- ***Any expenses for a sen/ice not approved and arranged by AIAS shall be excluded except that this exclusion shall be waived in the event that the insured person or hislher travelling companions cannot notify AIAS during an emergency medical situation for reasons beyond their control. In this case, the company reserves the right to reimburse the insured only for those expenses incun'ed for service which AIAS would provide under the same circumstances.***
- ***Any expenses incurred for the transportation of insured person's remains not approved and arranged by AIAS shall be excluded.***

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MEDICAL EXPENSES/HOSPITAL INCOME BENEFITS

Diagnosis made by Attending Physician:	Period of Hospitalisation:
Has the insured person ever suffered this or similar condition or a recurrence of a previous illness or injury?	❒ Yes ❒ No If Yes, please specify: Date of previous illness / injury: Insurance Co.s Involved: Amount Claimed: Circumstances:
Name(s) and address(es) of doctor(s) who attended to insured person:	
Name(s) and address(es) of insured person's usual doctor(s):	

Documents Required: (a) Original final medical bills and receipts (b) Medical Certificates (c) Medical report from doctors / dental surgeon confirming that surgery / dental treatment could not be delayed.

TRIP CANCELLATION / TRIP CURTAILMENT BENEFITS

When and where was the holiday booked?		
Reason for trip cancellation /trip curtailment:		
If cancellation /curtailment was due to death or serious accidental injury or serious sickness of an immediate family member, please state relationship to insured person:		
For **Trip Cancellation**, please provide :	For **Trip Curtailment**, please provide:	
Intended Departure Date:	Scheduled Insured Journey: From to (dd/mm/yy)	
Date Cancelled:	Date Insured Journey was interrupted: (dd/mm/yy)	
	Date of departure from the country due to interruption: (dd/mm/yy)	
Amount paid by the insured person:	Amount recovered from other sources:	Amount Claimed:

Documents Required: (a) Birth Certificate of insured person (b) Death Certificate of insured person or immediate family member or close business partner (where applicable) (c) Medical Certificates (d) Letter from doctor confirming that it was necessary to return to Singapore (e) Letter from your travel Agent / Carrier confirming: (i) Tour was cancelled (ii)The period of cancellation & (iii) The amount refunded or evidence proof that loss is claimed or refundable by other sources.

FLIGHT DELAY / BAGGAGE DELAY BENEFITS

For **Flight Delay**, please provide :	For **Baggage Delay**, please also provide:
Original Time, Date and Place of Departure:	Time and Date the insured person arrived at destination:
Original Flight No. and Airlines / Carrier:	
Actual Time, Date and Place ot Departure:	Actual Tme and Date when delayed baggage were delivered to and received by insured person:
Actual Flight No. and Airlines / Carrier:	

Documents Required: (a) Letter from Airlines / Carrier on the cause of delay and details to substantiate claim (b) Boarding Pass (c) Acknowledgement receipt for baggage received.

LOSS OF BAGGAGE / LAP TOP COMPUTER (EXTENSION COVER) / GOLFING EQUIPMENT (EXTENSION COVER) / PERSONAL MONEY & TRAVEL DOCUMENTS BENEFITS

(A) For items being stolen due to theft:
State location of Police Station where the insured person has filed the report and furnish us with a certified true copy of the report.

Date Reported:

Has a thorough search been made and notification sent to common carrier / hotel management? ❒ Yes ❒ No
If Yes, please furnish particulars of contact person and attach copies of correspondence to them:

Date Reported:

(B) For items being lost or damaged while property in the care/ custody of common carrier (airlines, bus company etc.) or hotel:
Has the insured person lodged a claim or complaint against the Carrier / Airline or hotel management or other authority or against any individual responsible for the loss or damage to the property?

❒ Yes ❒ No

If Yes, please give details, attach copies of correspondence and advise outcome of the insured person's claim against them:

Name of Carrier / Airline / Hotel, whichever is applicable:

Give details of items and amount claimed

Item lost / damaged	Description (make / model & brandname)	Place & Year Purchased	Original Purchase Price	Claim Amount

Documents Required: (a) Original receipts of all items claimed (b) Proof of ownership (c) Written documentation from hotel management and/or common carrier (d) Police report

PERSONAL LIABILITY BENEFITS

What is the name and address of the other party?

Nature of injuries sustained by the other party or extent of property damaged:

To which police officer or at which police station (if any) did the insured person report the incident?

Has a claim been made against the insured person? ❒ Yes ❒ No
If Yes, please give details and submit all relevant documents:

Name(s) and address(es) of witness(es) of the incident, if any:

Documents Required: (a) Attach all communication received.

BANK ACCOUNT INFORMATION OF POLICYOWNER

Name of Bank	Branch of Bank	Bank Account No.	Account Holder's Name

*Signature of Policyowner

Date

NB: Claim amount payable to policyowner (excluding reimbursement to CPF Board) up to $10,000 will be credited directly to the above bank account. For Claim amount payable to policyowner above $10,000, a cheque will be handed to your Financial Services Consultant/Insurance Representative for delivery.
* Please ensure that your signature is the same as the signature on your Application Form for Policy for verification purpose.

CLAIM SUMMARY (TO BE COMPLETED BY AGENCY LEADER)

	Days	Date	Amount
Medical Expenses (attach all bills & receipts):			
Hospital Income:			
Trip Cancellation / Trip Curtailment:			
Flight Delay / Baggage Delay:			
Loss of Baggage / Lap Top & Golfing Equipment (Extension):			
Personal Money & Travel Documents:			

Signature of Agency Leader & Agency Stamp
*** Please note that the Agency Leader's signature must be strictly executed on the signature section with the Agency Stamp.**

Name of FSC/IR: **Agency : SP/** **Contact No.:**

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PART 2 CERTIFICATE OF HOSPITALIZATION (TO BE COMPLETED BY DOCTOR AT INSURED PERSON'S EXPENSE)

Name of Patient: NRIC/FIN/Passport No.:

Date Admitted: Date discharged: Admission No.: Ward No.:

1. Date on which you first saw the patient for this condition. Of what symptoms did the patient complain?

2. (a) According to the patient, when did he/she first notice symptoms of condition?

(b) How long do you feel the symptoms has lasted prior to consulting you?

3. Was the patient referred to your hospital by a general practitioner? If so, please give name and address of the doctor concerned.

4. Had the patient previously seen any other doctor on account of these symptoms? If so, please give the name and address of the doctor concerned.

5 (a) What was your diagnosis?

(b) Date of first diagnosis:

(c) What other illness (if any) have contributed to the patient's condition?

(d) Did you inform the patient of your diagnosis? ❒ Yes ❒ No If yes, when did you do so?

(e) Is the patient aware of himself I herself having this condition prior to seeing you?

6. Nature of medical treatment given:

Type of operation performed:

Date performed:

Name of Surgeon:

7.	Any possibility of having a relapse?	❒ Yes	❒ No
8.	Is the patient's condition a congenital anomaly?	❒ Yes	❒ No
9.	Was this hospitalization related to pregnancy, miscarriage, abortion or childbirth?	❒ Yes	❒ No
10.	Was the patient's condition due to self-destruction or intentional self-inflicted injury?	❒ Yes	❒ No
11.	Was the patient's condition a mental or nervous disorder?	❒ Yes	❒ No
12.	Was this surgery for cosmetic reasons or dental treatment or an elective surgery?	❒ Yes	❒ No
13.	Was the patient's condition Aids-related or due to sexually transmitted disease?	❒ Yes	❒ No

14. Has the patient previously been treated for this condition or any other serious disorder? If so, please indicate:

	Dates	Diagnosis & Date of diagnosis	Details of treatment	Name of Doctor & Hospital
(a)				
(b)				
(c)				

15. Name of Hospital City / Town:

Name and Qualification of Doctor:

Date:

Signature of Doctor:

Name of Policy Owner:	NRIC/FIN/Passport No.:

AUTHORISATION & DECLARATION

I/We hereby authorise, agree and consent to:

(a) persons and organizations, whether within or outside Singapore, including but not limited to medical sources, hospitals, doctors, other healthcare professionals, laboratories, regulator, dispute resolution centres and insurers, their associated persons/organizations, my/our or the insured person's employers or financial service providers, or their third party service providers or representatives (collectively "**Third Parties**") disclosing and releasing to AIA Singapore, its associated persons/organizations, its and their third party service providers and its and their representatives, whether within or outside Singapore (collectively "**AIA Persons**"), any information concerning the policy owner and the insured person(s) at any time, including all personal data and information, medical information, medical history, consultation history and notes, prescriptions, treatments, descriptions of medical services rendered, and any employment and financial information, including the taking of copies of such records (collectively "**Personal Data**"), relevant for the Purpose (defined below);

(b) the AIA Persons sharing the scope of sub-clause

(c) the AIA Persons, including their approved medical examiners or laboratories, performing any necessary medical assessments and examinations and tests to determine, assess and evaluate the health of the insured person(s);

(d) the AIA Persons collecting, using, disclosing, storing, retaining and/or processing (collectively, "**Using**"/"**Use**") the Personal Data for the Purpose; and

(e) waive any right (on my own behalf and on behalf of the insured person(s) where applicable, in respect of which I/we represent and warrant that the insured person(s) have granted me/us authority to so waive) to bring a claim of any nature against any of the AIA Persons in respect of any above-mentioned Use and/or any Use of any Personal Data for the Purpose

Where I/we are not the insured person, I/we represent and warrant that I/we have obtained the consent of the insured person(s), except to the extent such consent is not required under relevant laws: (i) to collect their Personal Data; (ii) to disclose their Personal Data to the AIA Persons; and (iii) for the AIA Persons and Third Parties to Use any of their Personal Data in the manner and for the purposes described in this Clause. I/We hereby agree to indemnify AIA Persons for all losses and damages that AIA Persons may suffer in the event that I/we are in breach of any representation and warranty provided by me/us herein. In this Clause, "**Purpose**" means any of the purposes described in the AIA Personal Data Policy, including but not limited to processing of this form, to provide subsequent advice or services to me/us or the insured person in relation to any existing or future policy/policies/programmes that I/we may hold/participate with AIA Singapore.

I/We declare that all information is complete, true and correct and that no information or materials have been withheld and that AIA Singapore will rely and act on the Information accordingly.

I/We acknowledge and accept that AIA Singapore shall be at liberty to deny liability or recover amounts paid, whether wholly or partially, if any of the information is incomplete, untrue or incorrect in any respect or if the Policy does not provide cover on which such claim is made.

This authorisation and declaration shall bind my/our successors and assignees, and remains valid, notwithstanding death or incapacity. I/We agree that a photocopy of this authorisation shall be effective and valid as the original.

Date: Signature of Insured Person (Policyowner if Insured Person is a minor)

Note: No fees, commission or charges of whatever nature are payable to agents or employees of the Company in respect of this claim.