AIA SINGAPORE
PERSONAL LINES CLAIM FORM

Policy No : _____

Name of Insured : _____ Contact No : _____

Circumstances of Loss / Damage / Injury / Accident (Date of Claim / Where it Happened? / How it Happened?)

_____

_____

_____

_____

**Please provide proof of relationship when lost item(s) belongs to immediate family members and/or proof of travel if missing item(s) is not reported in origin country of loss.*

Is there any other insurance coverage on the same property insured? : Yes / No
Have you ever sustained any loss or damage of the same nature? : Yes / No

Description of Loss / Damage / Injury	Date Purchased	Price Paid
_____	_____	_____
_____	_____	_____
_____	_____	_____

For Singapore Only

To be completed by servicing FSC/IR (FSCs/IRs to ensure that * are completed as this will greatly assist Claims Department in processing the claims)

I am satisfied to my best knowledge that the facts stated in this claim form are true and accurate.

FSC/Insurance Representative's Name/Agency	FSC/Insurance Representative's Code	RNF Registration No.	Contact No.

_____
FSC/IR Signature & Date

PT0022316 (03/2012 06/2014 01/2016A)

AIA Singapore Private Limited (Reg. No. 201106386R)
AIA Customer Service Centre, 1 Finlayson Green, Singapore 049246
Monday to Friday: 8.45am – 5.30pm
AIA Customer Care Hotline: 1800 248 8000 AIA.COM.SG

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

1) * Please submit the duly completed and signed claim form with all relevant document(s) WITHIN 30 DAYS from the date of loss / damage / injury / accident.

2) For LOSS of Personal Valuables claim, please provide RECEIPT/S for the lost item(s) and POLICE REPORT/S. In the absence of documentary proof, the name and address of the shop whereby the item(s) was/were purchased will be helpful. If any of the above information is/are not available for any reasons, please include explanations.

3) For Medical Reimbursement for Accidents claims, please provide ORIGINAL MEDICAL RECEIPT/S, indicating the diagnosis and medical treatment rendered. In the absence of a hospital discharge report (if applicable) and/or medical certificate, please get the medical practitioner to fill up AIA PL Medical Certificate form at the back page. TCM is also covered but must be registered with MOH.

4) * For any claims made by the immediate family members, proof of relationship and a copy of the NRIC/FIN/Passport must also be submitted.

5) It is important to ensure that the answers to this claim form are true, accurate and complete to allow us to process the claim without any delay.

6) 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 (a) above, along with any of the Personal Data, with any relevant Third Parties to procure their disclosure and release of additional relevant Personal Data for the Purpose;
   (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.

7) 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.

_____ _____

Signature of Insured Date

CERTIFICATE OF MEDICAL ATTENDANT (To be completed by Attending Doctor at Insured's expense)

A) Patient's Particulars (From Hospital/Clinic's Record)

Patient's Name:	NRIC/Passport No./FIN No.:

B) Details Of Treatment And/Or Surgery (Please complete this part in full for all claims)

1. Was the patient hospitalised?

☐ Yes ☐ No If "Yes", please provide details.

Name & address of attending doctor(s)	Date Admitted	Date Discharged

2. Was the treatment or condition due to or related to any of the conditions listed?

☐ Yes ☐ No If "Yes", please tick the relevant box(es) :

☐ Sleep Disturbance Disorder
☐ Physical defects from childbirth
☐ Elective cosmetic / plastic surgery
☐ Mental / Nervous Disorder
☐ Sexually transmitted disease
☐ Correction for refractive errors of eye
☐ Birth control / Sterilization
☐ Congenital Anomaly
☐ Infertility / Sub-fertility
☐ Impotence test / treatment
☐ HIV/AIDS related
☐ Self-destruction / intentional self-inflicted injuries
☐ Drug Abuse / Drug Addiction
☐ Pregnancy
☐ Childbirth
☐ Miscarriage
☐ Abortion
☐ Dental
☐ Alcoholism

3. Please provide details on the type of treatment and/or surgery performed.

Type of Treatment/Surgery	Surgical Code	Name of Doctor(s)	Date of treatment

4. Was the patient treated by any other doctor(s) for the same condition?

☐ Yes ☐ No If "Yes", please provide details.

Name & Address of Doctor(s)	Date of consultation

5. Was the patient previously treated for any other serious condition(s)?

☐ Yes ☐ No If "Yes", please provide details.

Diagnosis/Illness	Name & Address of Doctor(s)	Date of diagnosis

6. Was any diagnostic test(s) or x-ray performed?

☐ Yes ☐ No If "Yes", please provide details below and submit a copy of the report(s).

Diagnosis Test(s)	Result(s)

7. Were there any complications that resulted in the healing being prolonged?

☐ Yes ☐ No If "Yes", please provide details below.

8. Is there any possibility of a relapse?

☐ Yes ☐ No If "Yes", please provide details below.

9. Was the patient referred to you?

☐ Yes ☐ No If "Yes", please provide details below.

Name of Doctor(s)	Name & Address of Clinic/Hospital

10. Was the patient reffered to a physiotherapist for further management?

☐ Yes ☐ No If "Yes", please provide details below.

Name of Physiotherapist	Name & Address of Clinic/Hospital

11. Are you the patient's regular doctor?

☐ Yes ☐ No If "Yes", please provide details below.

Name of Regular Doctor(s)	Name & Address of Clinic/Hospital

Patient's Name: NRIC/Passport No./FIN No.:

NOTE: Please complete Section (C) if treatment related to an accident OR Section (D) if treatment is related an illness.

C) Details Of Accident	
1. Date of accident.	Date :_____/_____/_____ (dd/mm/yy) Time:_____ am / pm
2. Please describe how the accident occurred.	
3. Please state the cause of the injury.	
4. Was the injury sustained consistent with the accident described above?	☐ Yes ☐ No If "No", please elaborate.
5. Please describe the injuries sustained and the anatomical site involved.	
6. Has the patient fully recovered from the injuries?	☐ Yes ☐ No If "No", please elaborate.
7. Did the patient's injuries result in permanent and total loss of use of the organ or limb involved?	☐ Yes ☐ No If "No", please state the extent of the loss of use of the limb/organ.
8. Would the injuries sustained have prevented the patient from working in his/her occupation?	☐ Yes ☐ No If "Yes", please elaborate.
9. Would the injuries sustained result in the patient's absence from work for more than 2 weeks?	☐ Yes ☐ No If "Yes", please elaborate.
10. Was the patient under the influence of alcohol or drugs at the time of the accident?	☐ Yes ☐ No If "Yes", please provide details below. Type of Alcohol / Drug Consumed | Blood Alcohol Level / Quantity Consumed
11. Was the patient suffering from any illness/infirmity which would likely have contributed to the injury or protracted the period of disability?	☐ Yes ☐ No If "Yes", please answer 11a - 11c. 11a. Please provide details below. Diagnosis | Date of diagnosis | Name & address of doctor(s) consulted 11b. How has the illness/infirmity contributed to the injuries or prolonged the period of disability? 11c. What would be the usual recovery time if not for the illness/infirmity?

Patient's Name: NRIC/Passport No./FIN No.:

D) Details Of Illness			
1. When did the patient **first** consult you for the condition?	Date :_____/_____/_____ (dd/mm/yy)		
2. What were the sign(s) and symptom(s) presented during the **first** consultation?			
3. When did the patient **first** notice the symptoms of the condition diagnosed?	Date :_____/_____/_____ (dd/mm/yy)		
4. In your opinion, how long have the symptoms lasted prior to the **first** consultation with you?			
5. Please state the exact diagnosis and the date of the diagnosis of the condition.	Diagnosis	Date of Diagnosis	
6. Was the patient informed of the diagnosis?	☐ Yes If "Yes", when was the patient informed? _____ (dd/mm/yy) ☐ No		
7. What was your advice to the patient?			
8. What is the underlying cause of the condition diagnosed?			
9. Was the patient aware of the condition diagnosed prior to seeing you?	☐ Yes ☐ No If "Yes", please elaborate.		
10. Has the patient consulted any other doctors/hospitals for the symptoms/ condition prior to the first consultation with you?	☐ Yes ☐ No If "Yes", please provide details.		
	Name of Doctor(s)	Name & Address of the Clinic(s)/Hospital(s)	Date of Consultation

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Patient's Name: NRIC/Passport No./FIN No.:

11.Are there <u>any other</u> illness(es) that would have contributed to the patient's condition?	☐ Yes ☐ No If "Yes", please answer 11a - 11c below.

11a. Please provide details.

Diagnosis	Date of diagnosis	Name & Address of doctor(s) who made the diagnosis

11b. Was the patient informed of the above diagnosis?

☐ Yes ☐ No

11c. When was the patient informed of the diagnosis?

Date :_____/_____/_____ (dd/mm/yy)

<u>IMPORTANT</u>: To enable us to proceed with the claim, kindly enclose copies of surgical reports, laboratory evidence, diagnostic test results and any other relevant hospital reports that are available.

E) Attending Doctor's Name & Signature

Name of Doctor : _____

Qualification : _____

Signature : _____

Date : _____

Address/Official Stamp: