AIA SINGAPORE
AIA PLATINUM HEALTH CLAIM FORM

Please note that all sections must be duly completed to avoid delay in the claim processing.
Please indicate as "NA" where item is not applicable and "Unknown" where item is not available.
* Please delete where appropriate.

Policy No. | | | | | | | | | | |

PART 1 (to be completed by the Insured/Policyowner)

PERSONAL PARTICULARS

Name of Insured	NRIC/FIN/PP No.*	Sex ❒ Male ❒ Female
Contact No.	Nationality	Age
Occupation and Name of Employer		
Name of Policyowner (if different from the Insured)	NRIC/FIN/PP No.*	Contact No.
Address (if different from what you have provided to AIA previously)		

Is the hospitalisation due to an accident? ❒ Yes ❒ No

If Yes, please provide the following
i. Date and time of accident _____
ii. Where and how it happened _____
iii. The extent and parts of body injured _____

Symptoms experienced and duration

Did the Insured consult any other doctors for the current condition? ❒ Yes ❒ No

If Yes, please provide the name(s) and address(ess) of the doctor(s): _____

_____

Did the Insured has any regular doctors(s)? ❒ Yes ❒ No

If Yes, please provide the name(s) and address(ess) of the doctor(s): _____

_____

Did the Insured has any other coverage by any other insurance company (other than AIA), employer, or any other parties? ❒ Yes ❒ No

If Yes, please indicate the name of insurance company, employer or any other relevant parties: _____

_____

PT0022356 (03/2012 06/2014 01/2016A)

Policy No.

Name of Insured _____ NRIC/FIN/PP No.* _____

PART 2 (to be completed by the attending doctor)

HOSPITAL/MEDICAL INSTITUTION DETAILS

Name of Hospital/Medical Institution	Date of admission/consultation* (DD/MM/YY)
	Estimated length of stay (in days)
Bill category (Please tick one)	Estimated size of bill (in S$)
❒ Inpatient ❒ Day Surgery ❒ Outpatient Clinic	Name of Hospital Staff Staff Contact No.

MEDICAL CONDITION/HISTORY

Diagnosis of illness/injury*	ICD9 Code	Date and time of accident (if applicable)	
Date of first diagnosis	(DD/MM/YY)	Date:	(DD/MM/YY)
		Time:	
Describe symptoms/how accident occurred*			
In your opinion, how long has the symptom(s) lasted prior to the consultation?			
According to the patient, when did he/she first notice the symptom(s) of the condition?			
Type of surgical procedure(s) and Operation Code(s)			
What other illnesses and/or conditions have contributed to the patient's condition?			
When was the first date of diagnosis of such illnesses/conditions?		(DD/MM/YY)	
Any possibility of a relapse?		❒ Yes	❒ No
Is the patient's condition a congenial anomaly?		❒ Yes	❒ No
Was this hospitalisation related to pregnancy, miscarriage, abortion or childbirth?		❒ Yes	❒ No
Was the patient's condition due to self-destruction or intentional self-inflicted injury?		❒ Yes	❒ No
Was the patient's condition a mental or nervous disorder?		❒ Yes	❒ No
Was this surgery for cosmetic reasons or dental treatment or an elective surgery?		❒ Yes	❒ No
Was the patient's condition AIDS-related or due to sexually transmitted disease?		❒ Yes	❒ No
Is the patient's condition due to an accident?		❒ Yes	❒ No
Has this illness/injury been treated before? If Yes, please indicate when it was treated and name of the attending doctor and clinic. (DD/MM/YY)		❒ Yes	❒ No
Name, contact number and address of referring doctor			
Name, contact number and address of regular clinic			
Name, contact number and address of attending doctor	Signature and Date	Official Stamp	

CLAIM PROCEDURES

1. Confirm the Insured's coverage under AIA Platinum Health plan.
2. Submit completed claim form and payment authorisation form to AIA Claims Department.
3. Upon the Insured's discharge, submit the original bills to AIA Claims Department for claims reimbursement.

NOTE

This claims assistance service is only available to an AIA Platinum Health Cardholder and the use of AIA's Claims Assistance Service is subject to the terms and conditions governing the AIA Platinum Health Privileges Programme.

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

AUTHORISATION AND DECLARATION

1. I/We hereby declare that the above statements and answers are true and complete to the best of my/our knowledge and belief.

2. I/We hereby irrevocably authorise any hospital, doctor, or other person/organisation/institution to furnish AIA Singapore Private Limited ("AIA Singapore") or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical record or reports, and other personal information of the Insured or Policyowner. This authorisation shall bind my/our successors and assigns and remain valid not withstanding my/our death or incapacity in so far as legally possible. I/We agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

3. 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.

4. I/We hereby authorise the payment of medical benefits due to me/us under the AIA Platinum Health policy contract to be made directly by AIA Singapore to Parkway Hospitals Singapore Pte Ltd ("Parkway") for the medical services that the hospital/medical institution stated in this claim form has provided and such payment to Parkway shall constitute good discharge of AIA Singapore's payment obligations hereunder.

5. I/We have been informed and am/are aware that Parkway shall be entitled, if it so chooses, to obtain payment directly from me/us for payment of the medical services stated in this claim form. In the event that I/we make payment to Parkway directly for the medical services stated in this claim form, I/we shall notify AIA Singapore immediately to revoke the above authorisation. In the event that AIA Singapore has made payment to Parkway for the medical benefits due to me/us under the AIA Platinum Health policy contract (the "Payment") before I/we have revoked the above authorisation, I/we acknowledge and agree that I/we shall recover the Payment from Parkway directly and that AIA Singapore shall not be liable for further payment or compensation to me/us.

6. I/We understand that AIA's obligation to pay any medical benefits shall not exceed what I/we are entitled to claim under the AIA Platinum Health policy contract, and hereby undertake and agree to pay Parkway for any and all charges incurred by me/us with Parkway that are not covered or payable under the AIA Platinum Health policy contract, including without limitation any difference in room rates and/or any charges for any medical treatment, services and/or supplies.

7. I/We agree that a photocopy of these authorisations and declarations shall be considered as effective and valid as the original.

NAME OF POLICYOWNER AND NRIC/FIN/PPNO.	SIGNATURE OF POLICYOWNER	SIGNATURE OF INSURED (NOT REQUIRED IF INSURED IS A MINOR)	DATE (DD/MM/YY)