



Please indicate the type of benefits you are claiming:

- H&S/HB
- CMP
- HI
- Others _____

HOSPITALIZATION CLAIM FORM

Important Notes:

1. For us to process the claims, this form must be completed in FULL and only ORIGINAL FINAL BILLS & RECEIPTS are attached.
2. This form is not for the submission of Healthshield Gold claims. All Healthshield Gold (including Prestige) claims must be filed via the Hospital at the time of admission/discharge. Healthshield Gold Essential claims will require ORIGINAL FINAL BILLS & RECEIPTS to be attached to the claim form.
3. All Non-English documents have to be accompanied with English translation (certification of the translator to be included).

PART 1 (To be completed by Insured or Policyowner if Insured is a minor)

Policy No. _____

(A) CLAIMANT'S PARTICULARS			
Name of Insured/Covered Member	Age Sex	NRIC No.	Name of Policyowner
Occupation	Name and Address of Employer		Relationship to Insured (if insured is not the claimant)
Contact No.			

This is a :

<input type="checkbox"/> New Claim	<input type="checkbox"/> Follow-up Claim	<input type="checkbox"/> Pending Claim
Please furnish: accident date/ hospitalization date: ____/____/____ (dd/mm/yy)		

(B) OTHER INSURANCE
(It is Compulsory for you to complete this section if you have other medical insurance coverage)

Is the claimant making a claim from other insurance companies? Yes. No.

If yes, please state: Name of insurance company _____ Policy Number _____
(Please submit a copy of other insurance company's claim settlement letter/payment voucher & bills/receipts)

(C) SUB (I) PLEASE COMPLETE THIS SECTION IF CLAIM IS DUE TO ACCIDENT

(1) Date of accident: ____/____/____ (dd/mm/yy)
Time of accident: ____/____/____ a.m. p.m.

(2) (a) Type of accident (please tick the relevant):

Road Traffic Accident <input type="checkbox"/>	Hit by heavy object/person <input type="checkbox"/>	Pricked by sharp object <input type="checkbox"/>
Industrial Accident <input type="checkbox"/>	Foreign body hitting eye <input type="checkbox"/>	Burns and scalds <input type="checkbox"/>
Slipped and Fell <input type="checkbox"/>	Cut by substance/device <input type="checkbox"/>	Bitten by insect/animal <input type="checkbox"/>

Others (please specify): _____

(b) Where and how did it happen: _____

(c) Describe the extent and part(s) of the body injured: _____

(d) What surgery was done or to be done? (if any): _____



(C) SUB (2) PLEASE COMPLETE THIS SECTION IF CLAIM IS DUE TO ILLNESS

(1) What is your doctor's diagnosis?

(2) Symptoms experienced : _____
How long have you been having these symptoms prior to admission to hospital?

(3) Give details of consultations:

(a) The doctor(s) you have consulted for this illness or symptoms

Date Name and address of doctors/hospitals

(b) Name and address of your regular doctor (other than the ones named above)

(4) Tick if the following tests/investigations were done/will be done:

(i) X ray/MRI/CT scan	<input type="checkbox"/>	(v) Blood test	<input type="checkbox"/>	(ix) Erythropoietin	<input type="checkbox"/>
(ii) ECG	<input type="checkbox"/>	(vi) Chemotherapy	<input type="checkbox"/>	(x) Cyclosporin	<input type="checkbox"/>
(iii) Biopsy	<input type="checkbox"/>	(vii) Radiotherapy	<input type="checkbox"/>	(xi) Immunotherapy	<input type="checkbox"/>
(iv) Pap smear	<input type="checkbox"/>	(viii) Renal Dialysis	<input type="checkbox"/>	(xii) Other investigations	<input type="checkbox"/>

(5) Have you undergone any surgery? Yes. No.
If yes, what is the name of the surgery? (please consult your doctor for the exact name of the surgery)

(6) For female claimants:-

(a) Were you pregnant at the time of hospitalization? Yes. No.
(a) Was the hospitalization related to the pregnancy? Yes. No.

(D) BANK ACCOUNT INFORMATION [AUTO BANK-IN CLAIMS PROCESSING]

<u>Name of Bank</u>	<u>Branch of Bank</u>	<u>Bank Account No.</u>	<u>Account Holder's Name</u>

NB: Claim amount payable to claimant (excluding reimbursement to CPF Board) up to \$ 10,000 will be credited directly to the above bank account. For claim amount payable above \$10,000, a cheque will be handed to your Financial Services Consultant (FSC) for delivery to you. Please be informed that reimbursement via GIRO can be made to the Policyowner's Bank account.

(E) AUTHORIZATION & DECLARATION

- I/We hereby irrevocably authorize any hospital, doctor, or other person/organization/institution to furnish American International Assurance Company, Limited ("the Company") 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 records or reports, and other personal information of the insured or policyowner. This authorization shall bind my/our successors and assigns and remain valid notwithstanding my/our death or incapacity in so far as legally possible. I/We agree that a photocopy of this authorization shall be considered as effective and valid as the original.
I/We hereby authorise, agree and consent to the Company to use and/or disclose any information collected and/or held (whether contained in this application or otherwise obtained) to enable the Company, its associated individuals/organisations and/or independent third parties, within or outside Singapore, with regard to any matters pertaining to the Application/Policy and/or any other policies that I/we currently may have with the Company, including but not limited to, processing of this Application, and/or providing subsequent services to me/us and/or providing advice and/or information concerning products and/or services which the Company believes may be of interest to me/us and/or communicating with me/us for any purpose.
I/We hereby specifically waive any right to bring a claim of any nature against the Company, its associated individuals/organisations and/or independent third parties, within or outside Singapore, in respect of any above-mentioned disclosure and/or any disclosure in the nature described above. This authorisation shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not my/our Application is accepted by the Company. A photocopy of this authorisation shall be effective and valid as the original.
- I declare that the answers given above are true and correct to the best of my knowledge and belief. I accept that AIA is at liberty to deny liability or recover amounts paid in part or full if the above information is false or inaccurate in any way.

Date _____ Signature of Insured/Covered Member _____
(Policyowner if Insured/Covered member is a minor)

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

CHECKLIST FOR THE CLAIMANT

Please ensure that the following are in order for the processing of claims:

- 1. Original Final Bills and receipts are provided (i.e not photocopy or interim bills).
- 2. All information (including Policy Number, name and all questions in Part 1) are filled up.
- 3. You have signed the "Authorization and Declaration" section using the signature at the time of policy application.
- 4. Part 2 of the Claim form has been filled up by the doctor at the insured's own expense.

POINTERS FOR FINANCIAL SERVICES CONSULTANT

Part 2 of the Claim Form can be waived if:

- (1) Rider has been in force for more than one year.
- (2) No claim on policy so far.
- (3) (a) Amount payable for Hospital Income is below \$500.00.
(b) Amount payable for Hospital expenses is below \$ 1,500.00.
- (4) Hospitalization period not exceeding:
 - (a) 4 days - if the basic policy / rider is less than 2 years.
 - (b) 7 days - if the basic policy / rider is more than 2 years.

NB. Notwithstanding the above, waiver of Part 2 of the Claim Form is at the discretion of the Company and the Company reserves the right to request for medical report when it deems necessary.

CLAIM SUMMARY (TO BE COMPLETED BY AGENCY LEADER)

	Day(s)	Date	Amount	Policy No.
Hospitalisation Benefit / Hospital Income	_____	_____	_____	_____
Hospital & Surgical Benefit	_____	_____	_____	_____
Healthshield	_____	_____	_____	_____
CMP	_____	_____	_____	_____
Others: _____	_____	_____	_____	_____

Signed by 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 _____ Agency : SP/ _____ Contact No. _____



PART 2 (To be completed by doctor at Insured's expense)

Name of Patient:	NRIC No.:		
Date admitted:	Date discharged:	Admission No.:	Ward No.:
(1) Date on which you first saw the patient for this condition. Of what <u>symptoms</u> 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 had 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 of the doctor concerned.			
(5) (a) What was your diagnosis? (b) Date of <u>first</u> diagnosis? (c) What other illnesses (if any) have contributed to the patient's condition? (d) Did you inform the patient of your diagnosis? If yes, <u>when</u> did you do so? (e) Is the patient aware of himself/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?			
(8) Is the patient's condition a congenital anomaly?	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.	
(9) Was this hospitalization related to pregnancy, miscarriage, abortion or childbirth?	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.	
(10) Was the patient's condition due to self-destruction or intentional self-inflicted injury?	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.	
(11) Was the patient's condition a mental or nervous disorder?	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.	
(12) Was this surgery for cosmetic reasons or dental treatment or an elective surgery?	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.	
(13) Was the patient's condition Aids-related or due to sexually transmitted disease?	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.	
(14) Is the patient's condition due to an accident?	<input type="checkbox"/> Yes.	<input type="checkbox"/> No.	
(15) Has the patient previously been treated for this condition or any other serious disorder? If so, please indicate:			
<u>Dates</u>	<u>Diagnosis & Date of diagnosis</u>	<u>Details of Treatment</u>	<u>Doctor's/Hospital Name</u>
(a)			
(b)			
(c)			
(16) Name of Hospital/Clinic _____ City/Town _____ Name and qualification of Doctor _____ Date _____ Signature _____ Hospital/Clinic Stamp			