



AIA SINGAPORE ACCIDENT & HOSPITALISATION CLAIM FORM

Important Notes:

- 1) AIA HealthShield Gold claims for Singaporeans and Permanent Residents must be submitted electronically via the medical institutions at the time of admission/discharge.
- 2) Please submit Inpatient Discharge Summary, **Original** Final Bills and Receipts (photocopy or interim bills are not acceptable).
- 3) For Accident Claims, please submit a copy of the Medical Leave Certificate (MC) if you are claiming for Weekly Indemnity Benefit.
- 4) Please ensure that you have signed the "Authorisation and Declaration" section using the same signature as in AIA Singapore's records.
- 5) You may visit our website (<http://www.aia.com.sg/en/index.html>) for the claim submission procedures.

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

A. POLICY DETAILS			
Policy Number(s) (Please list all policy numbers claiming for):		If Insured was hospitalised, please state: Date Admitted: ____/____/____ (dd/mm/yy) Date Discharged: ____/____/____ (dd/mm/yy)	
B. INSURED/COVERED MEMBER & POLICYOWNER'S PARTICULARS			
Name of Insured/Covered Member:		NRIC/Passport No./FIN No.:	Contact No.:
Mailing Address: _____ Postal Code ()			
Present Occupation:	Company Name & Business Address:	Exact Job Duties:	
Name of Policyowner (If different from Insured/Covered Member):		Policyowner's Relationship to Insured:	
C. BANK ACCOUNT INFORMATION FOR DIRECT CREDITING OF CLAIMS			
Name of Bank	Branch of Bank	Bank Account No.	Account Holder's Name
<p>Note: Direct crediting will only be applicable for claims (excluding reimbursement to CPF Board) up to SGD10,000 to a local bank account. A cheque will be issued if claim is above SGD10,000 or is a non-SGD dollar claim. Any follow-up claims will continue to be credited to the above Bank Account unless otherwise notified by the Policyowner. Claims will be paid to the Policyowner or otherwise in accordance with the terms of the policy or as permitted under applicable law.</p>			
D. GENERAL INFORMATION & DETAILS OF OTHER INSURANCE			
1. Please provide the name and address of the Insured's regular doctor(s).			
2. Please indicate if the Insured has undergone or will be going for any of these tests(s) and/or treatment(s). Tick the relevant box(es).	X-ray/MRI /CT scan <input type="checkbox"/>	ECG <input type="checkbox"/>	Biopsy <input type="checkbox"/>
	Chemotherapy <input type="checkbox"/>	Radiotherapy <input type="checkbox"/>	Immunotherapy <input type="checkbox"/>
	Renal Dialysis <input type="checkbox"/>	Pap Smear <input type="checkbox"/>	Cyclosporin <input type="checkbox"/>
	Erythropoietin <input type="checkbox"/>		
	Others (please specify) _____		
3. Did the Insured submit a claim with another Insurance Company or Third Party?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please complete the following and submit a copy of the claim settlement letter or payment voucher.		
	Name of Insurance Company/Third Party	Amount (SGD)	Policy No.
4. Is the current claim due to an accident?	Yes <input type="checkbox"/> If "Yes", complete Section (E) Details of Accident & Section (G) Authorisation & Declaration. No <input type="checkbox"/> If "No", complete Section (F) Details of Illness & Section (G) Authorisation & Declaration.		



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E. DETAILS OF ACCIDENT			
1. Please state the date, time and the place where the accident occurred.	Date of accident	Time of accident	Place of accident
	(dd/mm/yy)	am / pm	
2. Please indicate the cause of the accident. Tick the relevant box(es).	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) _____		
3. Please describe how the accident occurred.			
4. Please describe the injuries sustained.			
5. Please state the type of treatment(s) provided.			
6. Please provide the name and address of the doctor(s) consulted for the injury(ies) and the date(s) of consultation.	Name & Address of Doctor(s) consulted for injury(ies)		Date of Consultation
7. Has the Insured returned to work?	Yes <input type="checkbox"/> If "Yes", when did the Insured return to work? _____ (dd/mm/yy)		
	No <input type="checkbox"/> If "No", when is the Insured expected to return to work? _____ (dd/mm/yy)		
9. Is the Insured able to perform all work duties after the accident?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "No", please answer 9a) & 9b) below:		
	9a) What are the work duties that the Insured is unable to perform?		
	9b) When is the Insured expected to fully perform all work duties ? _____ (dd/mm/yy)		
10. Did the Insured submit any medical leave certificates to the employer?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
(F) DETAILS OF ILLNESS			
1. Please state the exact diagnosis of the condition.			
2. Please describe the symptom(s) experienced.			
3. Please state the date symptoms first occurred and the duration.			
4. Please provide the name and address of the doctor(s) consulted for the illness or symptoms and the date(s) of consultation.	Name & Address of Doctor(s)		Illness/ Symptoms
			Date of Consultation
5. Was surgery performed?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please provide details below:		
	Name & Address of Doctor(s)/Hospital(s)		Date of Surgery
	Type of Surgery		

(F) DETAILS OF ILLNESS (continued)**6. Females Only:**

- i. Was the Insured pregnant at the time of the hospitalisation?
 ii. Was the Insured's hospitalisation related to the pregnancy?

Yes No
 Yes No

If "Yes" to 6i and/or 6ii, please provide details below:

Name & Address of Obstetrician/Gynaecologist	Date of Consultation

(G) AUTHORISATION AND DECLARATION

- I/We, acknowledge and accept that the furnishing of this form, or of any other forms supplemental thereto, by AIA Singapore Private Limited ("AIA Singapore") (Reg. No. 201106386R) is neither an admission that there was any insurance in force on the life in question, nor an admission of liability nor a waiver of any of its rights or defenses.
- I/We:
 - hereby declare that I/we are duly authorised to make this claim and all statements and responses whether on this form or otherwise together with any required questionnaire, amendments, materials and supporting documents submitted in connection with the claim and the Policy ("Information");
 - 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. Otherwise, AIA Singapore shall be at liberty to deny liability or recover amounts paid, whether wholly or partially;
 - 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; and
 - acknowledge and accept that AIA Singapore expressly reserves its rights to require or obtain further information as it deems necessary.
- I/We hereby irrevocably authorise, agree and consent to:
 - Third Parties disclosing and releasing to the Recipients, any relevant information concerning the policyholder and the assured at any time including all personal and medical information, medical history, consultations, prescriptions, treatment, services rendered and copies of all such information including hospital and medical data, records and reports and in so far as employment and financial information are related to the policy, claim or the assessment of such claim, such employment and financial information as necessary; and
 - any of the Recipients disclosing any such information set out in paragraph 3(a) above to any of the Third Parties or another Recipient at any time; and
 - any of the Recipients including any of its or their approved medical examiners or laboratories to perform the necessary medical assessments, examinations and tests to determine, assess and evaluate the insured person's health; and
 - any of the Recipients using, processing, disclosing or communicating through any means, any information collected or held (whether contained in this form or otherwise) to any Third Parties, or with the policyholder or the insured person(s), for the Purpose;
 - hereby expressly release the Recipients and such other Third Parties to whom information is disclosed from any liabilities and waive any right to bring a claim of any nature against such persons, within or outside Singapore, in respect of such disclosure.
 - For such purposes: (i) "Third Parties" means any persons, organisations, institutions or bodies, within or outside Singapore, including but not limited to, medical sources, hospitals, doctors, other healthcare professionals, laboratories and insurance offices, associated or related parties, independent third parties, regulators, dispute resolution centres. (ii) "Recipients" means AIA Singapore, its or their agents, representatives and subcontractors. (iii) "Purpose" shall mean any matters pertaining to the claim, Policy, and/or any other existing or future policies that the policyholder or insured person may have with AIA Singapore, including but not limited to the provision of advice, information concerning other products, services and/or for any purpose.
- This authorisation and declaration shall bind my/our successors and assignees, and remains valid, notwithstanding death or incapacity. A photocopy of this authorisation shall be effective and valid as the original.

Date (dd/mm/yy)

Signature of Policyowner

Signature of Insured/Covered Member

(Not required if Insured/Covered Member is a minor)

Note: No fees, commissions or charges of whatever nature are payable to FSCs or employees of AIA Singapore in respect of this claim.

AGENCY LEADER'S SIGNATURE – Agency Leader's Recommendation (ALR) Scheme for Accident Claims

Date: _____ Agency Leader's Signature: _____ Agency Stamp: _____

Note: Agency Leader's recommendation is not an admission of AIA Singapore's liability nor waiver of our rights to request for further information. AIA Singapore reserves the right to request or obtain further information if deemed necessary.

FSC/Insurance Representative's Name:

FSC/Insurance Representative's Code

RNF Registration No.

Mobile No.



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

(A) PATIENT'S PARTICULARS (FROM HOSPITAL'S/CLINIC'S RECORD)

Patient's Name:	NRIC/Passport No./FIN No.:
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(B) DETAILS OF TREATMENT AND/OR SURGERY (Please complete this part in full for all claims)

1. Was the patient hospitalised?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please provide details below.		
	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 <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please tick the relevant box(es) : Congenital anomaly <input type="checkbox"/> Infertility / Sub-fertility <input type="checkbox"/> Sleep disturbance disorder <input type="checkbox"/> Physical defects from childbirth <input type="checkbox"/> Impotence test / treatment <input type="checkbox"/> Mental / Nervous Disorder <input type="checkbox"/> Pregnancy <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Drug Abuse / Drug Addiction <input type="checkbox"/> Childbirth <input type="checkbox"/> HIV/AIDS related <input type="checkbox"/> Alcoholism <input type="checkbox"/> Miscarriage <input type="checkbox"/> Elective cosmetic / plastic surgery <input type="checkbox"/> Self-destruction / intentional <input type="checkbox"/> Abortion <input type="checkbox"/> Correction for refractive errors of eye <input type="checkbox"/> self-inflicted injuries <input type="checkbox"/> Birth control / Sterilization <input type="checkbox"/> Dental <input type="checkbox"/>		
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 <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please provide details below.		
	Name & Address of Doctor(s)		Date of consultation
5. Was the patient previously treated for any other serious condition(s)?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please provide details below.		
	Diagnosis/ Illness	Name & Address of the Doctor(s)	Date of diagnosis
6. Was any diagnostic test(s) or x-ray performed?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please provide details below and submit a copy of the report(s).		
	Diagnostic Test(s)	Result(s)	
7. Were there any complications that resulted in the healing being prolonged?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please provide details of the complications.		
8. Is there any possibility of a relapse?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please elaborate.		
9. Was the patient referred to you?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes" please provide details below.		
	Name of Doctor(s)	Name & Address of Clinic/Hospital	
10. Was the patient referred to a physiotherapist for further management?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes" please provide details below.		
	Name of Physiotherapist	Name & Address of Clinic/Hospital	
11. Are you the patient's regular doctor?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "No" 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 (dd/mm/yy)		
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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> If "No", please elaborate.	
7. Did the patient's injuries result in <u>permanent</u> and total loss of use of the organ or limb involved?	Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please elaborate.	
9. Would the injuries sustained result in the patient's absence from work for more than 2 weeks?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please elaborate.	
10. Was the patient under the influence of alcohol or drugs at the time of the accident?	Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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?		



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Patient's Name:

NRIC/Passport No./FIN No.:

(D) DETAILS OF ILLNESS

1. When did the patient first consult you for the condition?	(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?	(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 diagnosis of the condition.	Diagnosis		Date of Diagnosis
6. Was the patient informed of the diagnosis?	Yes <input type="checkbox"/> If "Yes", when was the patient informed? _____ (dd/mm/yy) No <input type="checkbox"/>		
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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please provide details below.		
	Name of Doctor(s)	Name & Address of the Clinic(s)/Hospital(s)	Date of Consultation
11. Are there <u>any other</u> illness(es) that would have contributed to the patient's condition?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", please answer 11a -11c below.		
	11a. Please provide details below.		
	Diagnosis	Date of Diagnosis	Name & Address of Doctor(s) who made the diagnosis
	11b. Was the patient informed of the above diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/>		
11c. When was the patient informed of the diagnosis? _____ (dd/mm/yy)			

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

(E) ATTENDING DOCTOR'S NAME & SIGNATURE

<p>Name of Doctor : _____</p> <p>Qualification : _____</p> <p>Signature : _____</p> <p>Date : _____</p>	<p style="text-align: center;">Address/Official Stamp:</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
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