



Policy No : _____

Personal Lines Claim Form

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
_____	_____	_____
_____	_____	_____
_____	_____	_____

- * 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.
- 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.
- 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.
- * For any claims made by the immediate family members, proof of relationship and a copy of the NRIC/FIN/Passport must also be submitted.
- 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.
- I/We hereby authorize, agree & consent to AIA Singapore Private Limited ("the Company") to use &/or disclose any information collected &/or held (whether contained in this application or otherwise obtained) to enable the Company, its associated individuals/organizations &/or independent third parties, within or outside Singapore, with regard to any matters pertaining to the Application/Policy &/or other policies that I/we currently may have with the Company, including but not limited to, processing of this Application, &/or providing subsequent services to me/us &/or providing advice &/or information concerning products &/or services which the Company believes maybe of interest to me/us &/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/organizations &/or independent third parties, within or outside Singapore, in respect of any above-mentioned disclosure &/or any disclosure in the nature described above. This authorization shall bind my/our successors & assignees & remain valid, notwithstanding death, irrespective of whether or not my/our Application is accepted by the Company. A photocopy of this authorization shall be effective & valid as the original.

 Signature of Insured

 Date

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

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

Name of FSC/IR : _____
 Agency : _____
 Contact No : _____
 Fax No : _____

 FSC/IR Signature & Date

CERTIFICATE OF MEDICAL ATTENDANT (to be completed by medical practitioner)

No claim can be admitted unless medical certificate from a duly qualified medical practitioner on the form below is furnished at the expense of the Insured.

Name of patient: _____ NRIC/FIN/Passport No: _____.

(1) Information about the accident:

- a. Date of accident: ____/____/____ (dd/mm/yr) Time of accident: _____ a.m. p.m.
 b. Type of accident (please tick the relevant) information:

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

Others (please specify):

- c. Describe the cause of injury:
- d. Describe the extent of injury and part(s) of the body injured:
- e. Date when the patient/insured first consulted you on the injury?
- f. Has the patient/insured previously suffered from the illness or any related condition to the injury before? If yes, please give dates of consultations and the diagnosis.
- g. Did the patient receive medical leave certificate due to the injury? Yes No How long?

(2) Present condition of the injury.

(3) Treatment administered (such as number of stitches, physiotherapy, type of dressing, etc.)

<u>Date</u>	<u>Time (am/pm)</u>	<u>Treatment/Medication</u>	<u>Remarks</u> (complete/for follow-up)
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(4) Did injury require:

- a) Surgery? Yes No e) special diagnostic procedure? Yes No
 b) X-rays? Yes No
 c) Hospitalization Yes No Date Admitted: _____ Date Discharged: _____

(5) a) Was healing complicated? Yes No

b) If so, state reason for applying special treatment.

I certify that I have personally examined and treated the patient/Insured for the above injuries and that the facts as given above represent my opinion of his/her medical condition.

I/We hereby authorize, agree & consent to AIA Singapore Private Limited ("the Company") to use &/or disclose any information collected &/or held (whether contained in this application or otherwise obtained) to enable the Company, its associated individuals/organizations &/or independent third parties, within or outside Singapore, with regard to any matters pertaining to the Application/Policy &/or other policies that I/we currently may have with the Company, including but not limited to, processing of this Application, &/or providing subsequent services to me/us &/or providing advice &/or information concerning products &/or services which the Company believes maybe of interest to me/us &/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/organizations &/or independent third parties, within or outside Singapore, in respect of any above-mentioned disclosure &/or any disclosure in the nature described above. This authorization shall bind my/our successors & assignees & remain valid, notwithstanding death, irrespective of whether or not my/our Application is accepted by the Company. A photocopy of this authorization shall be effective & valid as the original.

Signed

Name of Physician:

Date

Address