



**AMERICAN INTERNATIONAL ASSURANCE COMPANY, LIMITED**  
(A Member Company of American International Group)

**ACCIDENT CLAIM FORM**

Please indicate the type of benefits you are claiming:

- PA   
AI   
EADD   
Others \_\_\_\_\_

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

Policy No. \_\_\_\_\_

*This printed form is forwarded on receipt of notice of an accident and its being sent is in no way an admission of claim.  
Part I & Part II of this form must be completed in full.*

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)		

**CLAIMANT'S PARTICULARS**

Name of Insured/Covered Member	Age Sex	NRIC No.	Name of Policyowner
Contact No.	Mailing Address		Relationship to Insured (if Insured is not the claimant)
Present Occupation (if more than one, state all)			
Exact Nature of Occupational duties			
Name, Address of business or employer			

**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 \_\_\_\_\_

Amount of Benefits \_\_\_\_\_

(Please submit a copy of other insurance company's claim settlement letter/payment voucher & bills/receipts)

**BANK ACCOUNT INFORMATION [AUTO BANK-IN CLAIMS PROCESSING]**

Name of Bank	Branch of Bank	Bank Account No.	Account Holder's Name

NB: Claim amount payable to claimant (excluding reimbursement to CPF Board) up to \$10,000 will be credited 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 only be made to the Policyowner's Bank Account



**INFORMATION PERTAINING 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): \_\_\_\_\_

(3) Name and address of Doctor(s) who has treated you for the injury

Date Consulted:

(4) Did you submit a medical leave certificate to your employer? Yes  No

(5) Date last worked prior to disability

(6) Date returned to work

(7) Date expected to return to work

(8) If you were not able to perform all duties immediately, indicate:

(a) Date returned to work

(b) Details of duties NOT able to be performed immediately

(c) Date which all duties were fully performed

**MEDISAVE-APPROVED INTEGRATED PLAN/ MEDICAL INSURANCE SCHEME**

**(A)** I confirm that I was continuously covered under the following Medisave-approved integrated plan/medical insurance scheme until I take up AIA HealthShield/HealthShield Gold policy (please tick the relevant box):

Medishield  Incomeshield / SupremeHealth / PRUShield / MyShield

Name of Payor: \_\_\_\_\_

Name of Payor: \_\_\_\_\_

NRIC No. of payor: \_\_\_\_\_

NRIC No. of payor: \_\_\_\_\_

Have you made any claim under the above Medisave-approved integrated plan/medical insurance scheme before?

Yes  No

If yes, please provide the following:

(1) Dates of hospitalisation \_\_\_\_\_

(2) Hospital \_\_\_\_\_

(3) Reason(s) for hospitalisation(s) \_\_\_\_\_

**(B)**  I confirm that I was not covered under any of the Medisave-approved integrated plan/medical insurance scheme before I take up AIA HealthShield/HealthShield Gold policy.

## AUTHORIZATION & DECLARATION

1. 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.

2. I declare that the answers given above are true to the best of my knowledge and belief.

Date \_\_\_\_\_ Signature of Covered Member (Policyowner if Covered Member is a minor) \_\_\_\_\_

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

### — End of Part I —

Thank you for completing Part I of the Claim Form. We have appended a checklist below to help you with the submission of your claim.

#### Checklist to help claimant along:

- Have you written down the policy number and your name?
- Have you completed all the questions in Part I ?
- Have you attached original Final Hospital Bills and Receipts and/or copy of medical leave certificate?
- Have you signed on the Authorization and Declaration columns?
- Is your signature consistent with that in the policy application?

#### Pointers for FSC:

Part II 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 II 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 (s)	Amount
Total Disability / Weekly Indemnity	_____	_____	_____
Partial Disability	_____	_____	_____
Hospital Indemnity	_____	_____	_____
Surgical Indemnity	_____	_____	_____
Medical Reimbursement	_____	_____	_____
Others: _____	_____	_____	_____
			Total: _____
	Date _____		

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

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

Name of Patient	NRIC No.:
(1) Date of Accident	
(2) (a) Describe the cause of injury.	
(b) Describe the extent of injury and state the anatomical site involved.	
(3) Present condition of the injury.	
(4) Does the injury result in the <u>permanent</u> total loss of use of the area involved? If so, please state the extent of such involvement.	
(5) Treatment administered (such as number of stitches, physiotherapy, type of dressing, etc.)	
<u>Date</u>	<u>Time (am/pm)</u>
<u>Treatment</u>	
(6) Was patient referred to physiotherapist for further management? If yes, please provide name and address of physiotherapist.	
(7) Name and address of other Physicians who attended the patient for the same injury.	
<u>Name</u>	<u>Address</u>
<u>Approximate Dates</u>	
(8) Did injury require	
(a) surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	(b) special diagnostic procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No
(c) x-rays? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(d) hospitalisation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Admitted _____      Date Discharged _____
(9) (a) Was healing complicated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(b) If so, state why and special treatment given.	
(10) Bearing in mind the patient's occupation as stated on page 1, do you feel that the injuries would have prevented him from working? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(11) If the answer is "Yes" to question 10 and an absence from work of more than two weeks was necessary, please describe in detail the reasons why you feel the patient could not return to work earlier.	
(12) Give details of any circumstances, such as intoxication, physical defects or medical history which may have contributed to the accident and/or lengthen the period of disability.	
I certify that I have personally examined and treated the Insured for the above injuries and that the facts as given above represent my opinion of his/her condition.	
Signature _____	Name of Physician _____
Date _____	Address _____