AIA SINGAPORE
AIA WANDERPLUS COVER (85434) CLAIM FORM
Corporate Solutions

3 Tampines Grande, #07-00, AIA Tampines, Singapore 528799, Email : sg.cs.campaign@aia.com

CLAIM PROCEDURES

FOR TRAVEL INCONVENIENCE

Please submit the following :-

a) Trip Cancellation / Postponement
   - Duly completed Section 1 of the Claim Form*
   - Other documents to substantiate the reason*
   - Original bills / receipts of advance payments and/or additional expenses incurred*
   - Copy of Air ticket or boarding pass*
   - Written confirmation from Airline stating compensation paid or payable*

b) Claims settlement (if payable) will be made payable to the insured member

FOR ACCIDENTAL DISMEMBERMENT CLAIM

Please submit the following :-

a) Duly completed Section 1 of the Claim Form*
b) Duly completed Section 2 of the Claim Form by the Attending Doctor*
c) Copies of CT Scan / MRI / X-ray or any other medical report*
d) Copy of Air ticket or boarding pass*
e) Claims settlement (if payable) will be made payable to the insured member

FOR ACCIDENTAL DEATH CLAIM

Please submit the following :-

a) Duly completed Section 1 of the Claim Form*
b) Copy of the Death Certificate*
c) Copy of Air ticket or boarding pass*
d) Copy of Police Report / Investigation Report*
e) Copy of Post Mortem / Autopsy Report including Toxicology Report / Coroner's inquest / Verdict (if any)
f) Certified True Copy of Claimant's identity card (front and back) *
g) Copy of Letter of Administration / Grant of Probate*
h) Claims settlement (if is payable) will be made payable to the Estate of the Insured Person

IMPORTANT NOTE

- Cost of Medical Report and/or medical evidence shall be borne by the Insured Person / Claimant.
- AIA reserves the right to pursue or obtain further information / document should it be deemed necessary.
- * Denote as Mandatory documents required for claim adjudication failing which the Insurer reserves the rights to reject the claim submission.
- The above benefit claim shall only be payable once per Insured Person regardless of the number of occurrences or number of policies in-force with AIA.
- Any other terms and conditions, please refer to the policy contract.

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Section 1 - Claimant's Statement

Please tick the applicable claim type and refer to page 1 for the claim requirements:

☐ **Travel Inconvenience** ☐ **Accidental Disablement Claim** ☐ **Accidental Death Claim**

Part A : To be completed by Claimant / Insured Member			
1) Name of Claimant		Claimant's NRIC / Passport No.	
Relationship to Insured Member	Contact No.	Personal Email Address	
2) Name of Insured Member		NRIC / Passport No.	Date of Birth (DD/MM/YY)
Personal Email Address		Gender ☐ Female ☐ Male	
Mailing Address for Claims Settlement Correspondence			

Part B : Claims Payment Details (For Travel Benefits & Accidental Dismemberment)					
Bank Name		Branch Code		Bank A/C No.	

Part C : Details of Accident			
1. Please state the date, time and the place where the accident occurred.	Date of accident (DD/MM/YYYY)	Time of accident AM / PM	Place of accident
2. Please indicate the cause of the accident. Tick the relevant box(es).	☐ Road Traffic Accident ☐ Hit by heavy object/ person ☐ Pricked by sharp object ☐ Industrial Accident ☐ Foreign body hitting eye ☐ Slipped and fell ☐ Cut by substance/device ☐ 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(s) of Consultation (DD/MM/YY)
7. Has the Insured returned to work?	☐ Yes If "Yes", when did the Insured return to work? _____ (DD/MM/YY) ☐ No If "No", when is the Insured expected to return to work? _____ (DD/MM/YY)		
8. Is the Insured able to perform all work duties after the accident?	☐ Yes ☐ No If "No", please answer 8a) & 8b) below: 8a) What are the work duties that the Insured is unable to perform? 8b) When is the Insured expected to fully perform all work duties ? _____ (DD/MM/YY)		
9. Did the Insured submit any medical leave certificates to the employer?	☐ Yes ☐ No		

Part D : Trip Cancellation

Intended Departure Date	Date cancelled
Amount Paid by You	Amount recovered from other source/claimed
When and where was the holiday booked?	
Why was the trip cancelled?	

Part F : Declaration and Authorisation

1) 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") is neither an admission that there was any insurance in force on the life in questions, nor an admission of liability nor a waiver of any of its rights or defences.

2) I/We declared that I/we am/are not an undischarged bankrupt. There are currently no actual or pending bankruptcy proceedings against me/us.

3) I/We
   a) 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 connections with the claim and the Policy ("Information");
   b) 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;
   c) acknowledge and accept that AIA Singapore shall be a liberty to deny liability or recover amount paid, whether wholly or partially, if any of the information is incomplete, untrue or incorrect in any respect of if the Policy does not provide cover on which such claim is made; and
   d) acknowledge and accept that AIA Singapore expressly reserves its rights or obtain further information as it deems necessary.

4) I/We hereby authorize, agree and consent to AIA Singapore to request from any hospital, physician, person or organization, all information with respect to any illness, injury, medical history, and copies of all hospital or medical records concerning myself at any time and authorize the prior mentioned organizations to disclose all such information to AIA Singapore.

5) I/We consent to AIA Singapore, its associated persons/organisations, third party service providers and representatives, whether within or outside Singapore (collectively "**AIA Persons**") to collect, use, disclose, store, retain and/or process (collectively, "**Use**") all personal data and information ("**Personal Data**") provided to AIA Persons or that they possess about me/us, in the manner and for the purposes described in the AIA Personal Data Policy ("**PD Policy**") which is available on AIA Singapore's website.

6) I/We agree to accept the provisions in the PD Policy as amended from time to time. Where Personal Data of another person is disclosed by me/us, I/we confirm that I/we have obtained the consent of the individual concerned, except to the extent such consent is not required under relevant laws to collect, use and/or disclose such Personal Data. I/We waive (on my/our own behalf and on behalf of each such other person) any right to claim against any of the AIA Persons for any Use in the nature of or for the purposes described above or in the PD Policy. I/We will indemnify AIA Persons for all losses and damages if I/we breach these provisions.

7) This consent shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not our Application/form is accepted by AIA Singapore. A photocopy of this consent shall be valid and effective as the original.

Signature of Insured Member / Claimant	Relationship to Insured Member	Date (DD/MM/YY)

Section 2 - Physician Statement – For Accidental Disablement Claim (to be completed by Attending Doctor at Insured's expense)

Name of Patient	NRIC / Passport No.

Part A : Details of Treatment and / or surgery (Please complete this part in full for all claims)

1. Was the patient hospitalised?

☐ Yes ☐ No 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 ☐ No If "Yes", please tick the relevant box(es) :

☐ Congenital anomaly	☐ Infertility / Sub-fertility	☐ Sleep disturbance disorder
☐ Physical defects from childbirth	☐ Impotence test / treatment	☐ Mental / Nervous disorder
☐ Pregnancy	☐ Sexually transmitted disease	☐ Drug abuse / Drug addiction
☐ Childbirth	☐ HIV/AIDS related	☐ Alcoholism
☐ Miscarriage	☐ Elective cosmetic / plastic surgery	☐ Self-destruction / Intentional
☐ Abortion	☐ Correction for refractive errors of eye	☐ Self-inflicted injuries
☐ Birth control / Sterilization	☐ Dental	

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 ☐ No 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 ☐ No 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 ☐ No 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 ☐ No If "Yes", please provide details of the complications.

8. Is there any possibility of a relapse?

☐ Yes ☐ No If "Yes", please elaborate.

9. Was the patient referred to you?

☐ Yes ☐ No 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 ☐ No If "Yes" please provide details below.

Name of Physiotherapist	Name & Address of Clinic/Hospital

11. Are you the patient's regular doctor?

☐ Yes ☐ No If "No" please provide details below.

Name of Regular Doctor(s)	Name & Address of Clinic/Hospital

Section 2 - Physician Statement – For Accidental Disablement Claim (to be completed by Attending Doctor at Insured's expense)

Name of Patient	NRIC / Passport No.

Part B : Details of Accident

1. Date of accident	
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 ☐ No 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 ☐ No If "No", please elaborate.
7. Did the patient's injuries result in permanent and total loss of use of the organ or limb involved?	☐ Yes ☐ No 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 ☐ No If "Yes", please elaborate.
9. Would the injuries sustained result in the patient's absence from work for more than 2 weeks?	☐ Yes ☐ No If "Yes", please elaborate.
10. Was the patient under the influence of alcohol or drugs at the time of the accident?	☐ Yes ☐ No 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 ☐ No 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?

Section 2 - Physician Statement – For Accidental Disablement Claim (to be completed by Attending Doctor at Insured's expense)

Name of Patient	NRIC / Passport No.

Part C : History and Circumstances Leading to Disability	
1. Date disability first started. (DD/MM/YY)	
2. Date when the patient first consulted you for this illness. (DD/MM/YY)	
3. Symptoms which the patient first related to you on the first consultation.	
4. According to the patient, the duration he / she had been experiencing these symptoms.	
5. Has the patient previously suffered from the illness or any related condition before?	☐ Yes ☐ No If "Yes", please give details of consultations and the resulting diagnosis.
Part D : Clinical and Physical Findings on First Consultation	
1. The symptoms or physical impairments of the patient observed by you at the first consultation.	
2. The diagnosis of the patient's condition.	
3. If the patient is suffering from Advanced Dementia (including Alzheimer's Disease), please complete the following questions.	
a) Is there evidence of deterioration or loss of intellectual capacity or abnormal behaviour resulting in significant reduction in mental and social functioning requiring the continuous supervision of the patient?	☐ Yes ☐ No If "Yes", please specify.
b) Did the deterioration or loss of intellectual capacity or abnormal behaviour arise from neurosis, psychiatric illness and any drug or alchohol organic disorder?	☐ Yes ☐ No If "Yes", please specify.
4. The date when the patient was first made aware of the illness. (DD/MM/YY)	

Section 2 - Physician Statement – For Accidental Disablement Claim (to be completed by Attending Doctor at Insured's expense)

Name of Patient	NRIC / Passport No.

Part E : Current Health Of Patient	
1. The date when the patient last consulted you. (DD/MM/YY)	
2. Please state the progress of recovery of the patient.	☐ Recovered ☐ Improving ☐ Static ☐ Retrogressed
3. Current state of mobility	☐ Ambulating without aid ☐ Ambulating without aid ☐ Confined to Bed ☐ Confined to Hospital ☐ Confined to wheelchair Please give name of the hospital and the period of hospital confinement, if any.
4. Based on your assessment on the patient, please indicate what best to describe the patient's disability status.	☐ Good recovery – can lead a full and independent life with or without minimal neurological deficit. ☐ Moderately disabled – has neurological or intellectual impairment but independent. ☐ Severely disabled – conscious but totally dependent on others to get through daily activities. ☐ Vegetative survival.
5. Is the patient able to return to his / her usual occupation?	☐ Yes ☐ No
If "Yes", when can he / her return to work? What is the limitation?	
If "No",	a) Please elaborate to what extend does his / her disability prevent him / her from performing all the normal duties of his / her usual occupation?
	b) When can he / her return to work? What is the limitation?
	c) What other type of occupation can the patient perform?
6. Please provide us with any other additional information that will enable the company to assess this claim.	

Section 2 - Physician Statement – For Accidental Disablement Claim (to be completed by Attending Doctor at Insured's expense)

Activities of Daily Living (ADL)

Name of Patient	NRIC / Passport No.

Please comment on whether the patient is able to perform the following activities of daily living :-

Activity	Score		
Feeding 0 = unable 5 = need help cutting, spreading butter, etc., or requires soft diet 10 = independent	**0**	**5**	**10**
Bathing 0 = dependent 5 = independent (or in shower)	**0**		**5**
Grooming 0 = needs to help with personal care 5 = independent (face / hair / teeth / shaving (implements provided))	**0**		**5**
Dressing 0 = dependent 5 = need help but can do about half unaided 10 = independent (including buttons, zip, laces, etc)	**0**	**5**	**10**
Bowels 0 = incontinent (or needs to be given enemas) 5 = occasional accident 10 = continent	**0**	**5**	**10**
Bladder 0 = incontinent or catheterized and unable to manage alone 5 = occasional accident 10 = continent	**0**	**5**	**10**
Toilet Use 0 = dependent 5 = needs some help, but can do something alone 10 = independent (on and off, dressing, wiping)	**0**	**5**	**10**

Section 2 - Physician Statement – For Accidental Disablement Claim (to be completed by Attending Doctor at Insured's expense)

Activities of Daily Living (ADL)

Name of Patient	NRIC / Passport No.

Activity	Score
Transfer (bed to chair and back) 0 = unable, no sitting balance 5 = major help (one or two people, physical), can sit 10 = minor help (verbal or physical) 15 = independent	**0 5 10 15**
Mobility (on level surfaces) 0 = immobile or < 50 yards 5 = wheelchair independent, including corners, > 50 yards 10 = walks with help of one person (verbal or physical) > 50 yards 15 = independent (but may use any aid; for example, stick) > 50 yards	**0 5 10 15**
Stairs 0 = unable 5 = needs help (verbal, physical, carrying aid) 10 = independent	**0 5 10**

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.

Signature of Doctor	Date (DD/MM/YY)
Name / Designation	Name and Address of Clinic / Hospital & Stamp