



**AIA SINGAPORE
AIA TRAVEL AWESOME CAMPAIGN
FREE TRAVEL INSURANCE POLICY CLAIM FORM
CORPORATE SOLUTIONS**

3 Tampines Grande, #07-00, AIA Tampines, Singapore 528799, Fax: 6538 5603 / 6538 4340, Email : sg.cs.campaign@aia.com

CLAIM PROCEDURES

FOR TRAVEL INCONVENIENCE

Please submit the following :-

- a) Trip Cancellation
 - Duly completed Section 1 of the Claim Form
 - Duly completed Section 2 of the Claim Form by the Attending Doctor and/or
 - 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) Flight Delay / Baggage Loss or Delay / Personal Effects
 - Duly completed Section 1 of the Claim Form
 - Written confirmation from airline stating the period of delay and reason(s)
 - Copy of trip itinerary
 - Airline Property Irregularity Report and confirmation letter on when baggage was returned
 - Copy of police report
 - Original Receipt of purchase
 - Photograph of damage
 - Copy of Air ticket or boarding pass
 - Written confirmation from Airline stating compensation paid or payable

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

FOR ACCIDENTAL DEATH CLAIM

Please submit the following :-

- a) Duly completed Section 1 of the Claim Form.
- b) Certified True Copy of the Death Certificate (to be verified by AIA Customer Service Officer)
- c) Copy of Police Report / Investigation Report
- d) Copy of Post Mortem / Autopsy Report including Toxicology Report (if any)
- e) Copy of 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

Important Note:

- Every question must be distinctly and fully answered
- The above are the basic documents required for filing the claim, any other additional documents required will depend on the case itself.
- 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.



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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.	
2) Name of Insured Member		NRIC / Passport No.	Date of Birth (DD/MM/YY)
Contact No.	Email Address		Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
Mailing Address			
Part B : Claims Payment Details			
Cheque Payee Name :			
Part C : 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/YYYY)	AM / PM	
2. Please indicate the cause of the accident. Tick the relevant box(es).	<input type="checkbox"/> 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"/> Slipped and fell <input type="checkbox"/> Cut by substance/device <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(s) of Consultation (DD/MM/YY)
7. Has the Insured returned to work?	<input type="checkbox"/> Yes If "Yes", when did the Insured return to work? _____ (DD/MM/YY) <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No		



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Part D : Trip Cancellation

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

Part E : Luggage and Personal Effects

Give details of amount claimed					
No.	Description	When & where purchased	Original purchase price	Depreciation for wear & tear	Amount claimed

Part F : Flight Delay / Baggage Delay

Original Flight Details / Delay Flight Details	Collection of Baggage Detail	Retrieval of Delayed Baggage
Original date of departure: Rescheduled date of departure: Original Departure date: Reschedule Departure Time: Place of Departure: Original Flight No: Reschedule Flight No. Name of Airline:	Place of Arrival: Date of Arrival: Time of Collection: Cause of Baggage Delay:	Place of Collection: Date of collection: Time of collection:



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Part G : 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 at 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)

Part H : Declaration on U.S. Person Status (please tick the box as appropriate)

I/We hereby declare and agree that I am/we are not a "U.S. person" for U.S. federal income tax purposes and that I am/we are not acting for, or on behalf of a U.S. person. I/We understand that AIA Singapore, believing this statement to be true, will rely on it and act on it. In the event this statement is false, AIA Singapore reserves the right and shall be entitled to cancel or terminate this Policy/Policies and pay reasonable compensation to me/us in consideration of such cancellation or termination as may be required under Singapore laws.

I/We agree to notify AIA Singapore within 30 days of any change in my/our status as a U.S. person for the purposes of U.S. federal income tax. I/We agree to indemnify AIA Singapore in respect of any false or misleading information regarding my/our "U.S. person" status for U.S. federal income tax purposes.

☐ By ticking the box on the left, I/we hereby declare and agree that I am/we am a "U.S. person" for U.S. federal income tax purposes. I agree to notify AIA Singapore within 30 days of any change in my/our status as a U.S. person for the purposes of U.S. federal income tax. I/We agree to indemnify AIA Singapore in respect of any false or misleading information regarding my/our "U.S. person" status for U.S. federal income tax purposes.

Note: Please submit duly completed W-9 form to us. You can download a copy of the W-9 form from our corporate website www.aia.com.sg

Signature of Insured Member / Claimant

Relationship to Insured Member

Date (DD/MM/YY)



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Section 2 - Medical Report – 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please tick the relevant box(es) :		
	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> Congenital anomaly</div> <div style="width: 33%;"><input type="checkbox"/> Infertility / Sub-fertility</div> <div style="width: 33%;"><input type="checkbox"/> Sleep disturbance disorder</div> <div style="width: 33%;"><input type="checkbox"/> Physical defects from childbirth</div> <div style="width: 33%;"><input type="checkbox"/> Impotence test / treatment</div> <div style="width: 33%;"><input type="checkbox"/> Mental / Nervous disorder</div> <div style="width: 33%;"><input type="checkbox"/> Pregnancy</div> <div style="width: 33%;"><input type="checkbox"/> Sexually transmitted disease</div> <div style="width: 33%;"><input type="checkbox"/> Drug abuse / Drug addiction</div> <div style="width: 33%;"><input type="checkbox"/> Childbirth</div> <div style="width: 33%;"><input type="checkbox"/> HIV/AIDS related</div> <div style="width: 33%;"><input type="checkbox"/> Alcoholism</div> <div style="width: 33%;"><input type="checkbox"/> Miscarriage</div> <div style="width: 33%;"><input type="checkbox"/> Elective cosmetic / plastic surgery</div> <div style="width: 33%;"><input type="checkbox"/> Self-destruction / Intentional</div> <div style="width: 33%;"><input type="checkbox"/> Abortion</div> <div style="width: 33%;"><input type="checkbox"/> Correction for refractive errors of eye</div> <div style="width: 33%;"><input type="checkbox"/> Self-inflicted injuries</div> <div style="width: 33%;"><input type="checkbox"/> Birth control / Sterilization</div> <div style="width: 33%;"><input type="checkbox"/> Dental</div> </div>		
3. Please provide details on the type of treatment and/or surgery performed.	Type of Treatment/Surgery	Surgical code	Name of Doctor(s)
4. Was the patient treated by any other doctor(s) for the same condition?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details of the complications.		
8. Is there any possibility of a relapse?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please elaborate.		
9. Was the patient referred to you?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please provide details below.		
	Name of Physiotherapist	Name & Address of Clinic/Hospital	
11. Are you the patient's regular doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "No" please provide details below.		
	Name of Regular Doctor(s)	Name & Address of Clinic/Hospital	



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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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please elaborate.		
9. Would the injuries sustained result in the patient's absence from work for more than 2 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please elaborate.		
10. Was the patient under the influence of alcohol or drugs at the time of the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> 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/infirmary which would likely have contributed to the injury or protracted the period of disability?	<input type="checkbox"/> Yes <input type="checkbox"/> 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/infirmary contributed to the injuries or prolonged the period of disability?		
	11c. What would be the usual recovery time if not for the illness/infirmary?		



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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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 alcohol organic disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please specify.
4. The date when the patient was first made aware of the illness. (DD/MM/YY)	



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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.	<input type="checkbox"/> Recovered <input type="checkbox"/> Improving <input type="checkbox"/> Static <input type="checkbox"/> Retrogressed
3. Current state of mobility	<input type="checkbox"/> Ambulating without aid <input type="checkbox"/> Ambulating without aid <input type="checkbox"/> Confined to Bed <input type="checkbox"/> Confined to Hospital <input type="checkbox"/> 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.	<input type="checkbox"/> Good recovery – can lead a full and independent life with or without minimal neurological deficit. <input type="checkbox"/> Moderately disabled – has neurological or intellectual impairment but independent. <input type="checkbox"/> Severely disabled – conscious but totally dependent on others to get through daily activities. <input type="checkbox"/> Vegetative survival.
5. Is the patient able to return to his / her usual occupation? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	



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Section 3 : 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



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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
<u>IMPORTANT:</u> 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.	
<div style="border-top: 1px solid black; margin-bottom: 5px; text-align: center;">Signature of Doctor</div> <div style="border-top: 1px solid black; margin-bottom: 5px; text-align: center;">Name / Designation</div>	<div style="border-top: 1px solid black; margin-bottom: 5px; text-align: center;">Date (DD/MM/YY)</div> <div style="border-top: 1px solid black; margin-bottom: 5px; text-align: center;">Name and Address of Clinic / Hospital & Stamp</div>