ACCIDENT AND HOSPITALISATION CLAIM CLAIM PROCEDURE

DOCUMENTS REQUIRED

***If this is a <u>First Claim</u>** (i.e. first claim for an accident or illness)*

1. Accident & Hospitalisation Claim Form
2. Final Bills and Receipts (interim bills are not acceptable)
3. Copy of Detailed Inpatient Discharge Summary and any medical or diagnostic reports, if available
4. Copy of the Police Report or Accident Report, if available
5. Copy of the claim settlement letter and payment voucher if there was a reimbursement from another Insurer/ Employer
6. Copy of the Medical Leave Certificate (MC) for claims on Weekly Indemnity/Temporary Disability Indemnity Benefits
7. Clinical Abstract Application Form
8. Part II Certificate of Medical Attendant of the Accident & Hospitalisation Claim Form (Please refer to Important Notes (b) below)

***If this is a <u>Follow-Up Claim</u>** (i.e. further submission to a previous claim)*

1. Follow-Up Claim Form (Please refer to Important Notes (c) below)
2. Final Bills and Receipts (not interim bills)
3. Copy of the claim settlement letter and payment voucher if there was a reimbursement from another Insurer / Employer
4. Copy of the Medical Leave Certificate (MC) if claiming under Weekly Indemnity/Temporary Disability Indemnity Benefit

IMPORTANT NOTES

(a) The Follow-Up Claim Form is only applicable for follow-up submission to a previous claim e.g. post-hospitalisation expenses, additional medical leave certificate, etc.

(b) All documents submitted must be in English. Any document that is not in English must be accompanied by an English translated copy of the document made by a certified translator/interpreter.

(c) All forms must be duly completed and signed to avoid delay in claim processing. Please indicate “N.A.” for fields which are not applicable.

SUBMISSION OF DOCUMENTS

All claims required documents can be submitted to AIA Singapore. You may submit the claim application together with all of the requirement to AIA Singapore in any of the following way:

- By postal mail to AIA Singapore Claims Department at
  AIA Singapore Claims Department
  3 Tampines Grande #09-01
  Singapore 528799
  Attention: Claims Department (Individual Life & Health)

- Contact your AIA Servicing Agent to assist you.

- Submit your claim application in person at <u>AIA Singapore Customer Service Centre</u>

  Finlyson Green at **1 Finlayson Green, Singapore 049246**
  Operating Hours: Mondays to Fridays 9am to 5.30pm excluding Public Holidays

AIA SINGAPORE
ACCIDENT & HOSPITALISATION CLAIM FORM

Important Notes:
1) Please submit Inpatient Discharge Summary, Final Bills and Receipts (interim bills are not acceptable).
2) For Accident Claims, please submit a copy of the Medical Leave Certificate (MC) if you are claiming for Weekly Indemnity Benefit.
3) Please ensure that you have signed the "Authorisation and Declaration" selection using the same signature as in AIA Singapore's records.
4) You may visit our website (https://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

Policy Number(s) (Please indicate the policy number for the benefit(s) you would like to claim):

B) Cause Of Claim

☐ Accident

L1ACCFM

☐ Illness

L1HOSFM

Is mandatory to select the cause of claim. Tick one box only.

C) 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:

D) Payment Methods

- Claim payment up to Singapore Dollar $200,000.00 will be paid to the Policyholder's NRIC/FIN number registered PayNow account with a Singapore bank. Please ensure you have an active NRIC/FIN number registered PayNow account with your designated Bank. If the PayNow payment is unsuccessful, an SMS will be sent to the policyowner. A cheque will be automatically issued and mailed directly to the mailing address of the policy. Please ensure that the mailing address of the policy is valid.
- If there are multiple claimants for this claim, e.g. multiple trustees, the claim will be paid by cheque payment and we will send the cheque to the mailing address of the policy.
- Claim payment for non-Singapore currency policy will be paid in cheque.
- For overseas claimant, claim payment will be made via Telegraphic Transfer (TT) to a designated overseas bank. You may download the TT form from our website under "Submit A Claim".

E) General Information & Details Of Other Insurance

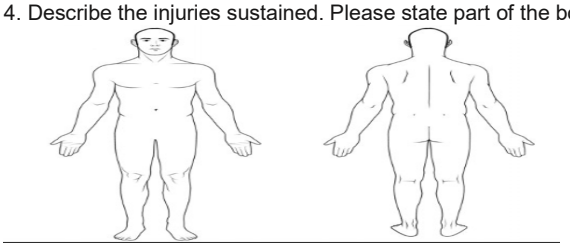
1. Did the Insured submit a claim with another Insurance Company or Third Party?	☐ Yes ☐ No If "Yes" please complete the following and submit a copy of the claim settlement letter or payment voucher.		
	Name of Insurance Company/ Third Party	Amount (SGD)	Policy No.

F) Type Of Benefit Claim

Please select the type of benefit(s) you wish to claim:

Tick	**Type Of Benefit Claim**	**Supporting Document**
☐	Medical Reimbursement Benefit (non-Traditional Chinese Medicine)	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. A copy of valid pass (for non Singapore Citizen or non Permanent Resident) 3. Final bill/tax invoice/receipt(s) 4. Detailed breakdown dates and charges for physiotherapy sessions 5. Certified true copy of valid pass (for Non-Singapore Citizen and non-Singapore PR)
☐	Traditional Chinese Medicine Benefit (*only for accident, cancer, stroke)*	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Final bill/tax invoice/receipt(s) 3. Detailed breakdown dates and charges for Traditional Chinese Medicine sessions 4. Certified true copy of valid pass (for Non-Singapore Citizen and non-Singapore PR)
☐	Pre / Post Hospitalisation Benefit	1.Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Final bill/tax invoice/receipt(s) 3. Detailed breakdown dates and charges for physiotherapy sessions
☐	Hospital Income/ Hospital Care Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. A copy of the final hospital bill with the admission and discharge date 3. Inpatient discharge summary / clinical summary 4. Certified true copy of valid pass (for Non-Singapore Citizen and non-Singapore PR)
☐	Weekly Indemnity Benefit (This benefit is only for accident claim)	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. A copy of Medical Certificates (MC)
☐	Fracture Benefit (This benefit is only for accident claim)	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. A copy of the X-ray/MRI/CT scan reports pertaining to the fracture injury sustained.
☐	Mobility Aids Benefit (This benefit is only for accident claim)	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Doctor's memo/ written prescription stating the reason for purchase of mobility aid 3. Final bill/tax invoice/receipt(s)
☐	Recuperation Benefit (This benefit is only for Hand, Foot and Mouth Disease and dengue)	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Certified true copy of valid pass (for Non-Singapore Citizen and non-Singapore PR)
☐	Ambulance Service Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I 2. Final bill/tax invoice/receipt(s)
☐	Post Hospitalisation Home Rest Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. A copy of Medical Certificates (MC)
☐	Emergency Outpatient Treatment Accident Benefit (This benefit is only for accident claim)	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Final bill/tax invoice/receipt(s)
☐	Pregnancy Complication Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Final bill/tax invoice/receipt(s)
☐	Congenital Abnormalities of Insured Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Final bill / tax invoice/receipt(s)
☐	Accidental Dismemberment Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. A copy of the X-ray/MRI/CT scan reports pertaining to the fracture injury sustained

G) Details Of Accident

1. State the date, time and the place where the accident occurred.	Date of accident dd/mm/yy	Time of accident	Place of accident
	(dd/mm/yy)	am / pm	
2. Describe how the accident occurred			
3. Was a police report filed?	☐ Yes ☐ No If yes, please enclose a copy of the police report		
4. Describe the injuries sustained. Please state part of the body 			
5. State the type of treatment(s) provided.			
6 If the treatment received was as a result of a dental injury, please provide details of the injured tooth	6a. Which tooth has been injured?		
	6b. Was there any existing conditions of the injured tooth prior to the accident (eg, decay, periodontal disease, and existing crown/bridge)? ☐ Yes ☐ No If yes, was it in good repair, at the time of accident? ☐ Yes ☐ No		
	6c. Please provide name and address of doctor for the treatment of injured tooth		
7. 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 dd/mm/yy
8. Name and address of the regular / company / family doctor(s)			
9. Have the insured been given hospital/medical leave?	☐ Yes ☐ No If "Yes", please provide a copy of medical certificate.		
10. Did insured submit medical certificate to employer?	☐ Yes ☐ No		

11. 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)
12. Is the Insured able to perform all work duties after the accident?	☐ Yes ☐ No If "No", please answer 12a.and 12b.
	12a. What are the work duties that the Insured is unable to perform?
	12b. When is the Insured expected to fully perform all work duties?

H) Details Of Illness

1. State the periods of hospitalisation	Period of hospitalisation	
	Date of hospital admission: (dd/mm/yy)	Date of hospital discharge: (dd/mm/yy)
2. Details of doctor and hospital admitted for this illness	Name of doctor	Name of admitted hospital
3. Exact diagnosis made on the Insured.		
4. Date of diagnosis first established. (dd/mm/yy)		
5. When the symptom first started? (dd/mm/yy)		
6. Describe the symptom(s) experienced.		

7. 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 dd/mm/yy

8. Name and address of the regular / company / family doctor(s)	Name & Address of Doctor(s)

9. Was surgery performed?	Name & Address of Doctor(s)/Hospital(s)	Name of Surgery	Date of Surgery dd/mm/yy

Patient's Name :
Patient's NRIC/Passport No./FIN No.:
Policy Number :

I) Authorisation And Declaration

Patient Name: _____ **Patient's NRIC/Passport no./Fin no.: _____**

1. I/We, acknowledge and accept that the furnishing of this form, or of any 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.

2. 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 connection 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 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.
   (d) declare that I/we did not file duplicate claim with AIA Singapore or any other insurer or source on the same bills which I/we have submitted for claims with AIA Singapore. I/We agree that AIA Singapore shall reject my/our claim or clawback any money paid to me/us should it be found that I/we have received reimbursement elsewhere.

3. I/We hereby authorise, agree and consent to:
   (a) persons and organizations, whether within or outside Singapore, including but not limited to medical sources, hospitals, doctors, other healthcare professionals, laboratories, regulator, dispute resolution centres and insurers, their associated persons/organizations, my/our or the insured person's employers or financial service providers, or their third party service providers or representatives (collectively **"Third Parties"**) disclosing and releasing to AIA Singapore, its associated persons/organizations, its and their third party service providers and its and their representatives, whether within or outside Singapore (collectively **"AIA Persons"**), any information concerning the policy owner and the insured person(s) at any time, including all personal data and information, medical information, medical history, consultation history and notes, prescriptions, treatments, descriptions of medical services rendered, and any employment and financial information, including the taking of copies of such records (collectively **"Personal Data"**), relevant for the Purpose (defined below);
   (b) the AIA Persons sharing the scope of the sub-clause (a) above, along with any of the Personal Data, with any relevant Third Parties to procure their disclosure and release of additional relevant Personal Data for the Purpose;
   (c) the AIA Persons, including their approved medical examiners or laboratories, performing any necessary medical assessments and examinations and tests to determine, assess and evaluate the heath of the insured person(s);
   (d) the AIA Persons collecting, using, disclosing, storing, retaining and/or processing (collectively, **"Using"/"Use"**) the Personal Data for the Purpose; and
   (e) waive any right (on my own behalf and on behalf of the insured person(s) where applicable, in respect of which I/ we represent and warrant that the insured person(s) have granted me/us authority to so waive) to bring a claim of any nature against any of the AIA Persons in respect of any above-mentioned Use and/or any Use of any Personal Data for the Purpose.

   Where I/we are not the insured person, I/we represent and warrant that I/we have obtained the consent of the insured person(s), except to the extent such consent is not required under relevant laws: (i) to collect their Personal Data; (ii) to disclose their Personal Data to the AIA Persons; and (iii) for the AIA Persons and Third Parties to Use any of their Personal Data in the manner and for the purposes described in this Clause. I/We hereby agree to indemnify AIA Persons for all losses and damages that AIA Persons may suffer in the event that I/we are in breach of any representation and warranty provided by me/us herein. In this Clause, **"Purpose"** means any of the purposes described in the AIA Personal Data Policy, including but not limited to processing of this form, to provide subsequent advice or services to me/us or the insured person in relation to any existing or future policy/policies/programmes that I/we may hold/participate with AIA Singapore.

4. 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** Name: NRIC:	**Signature of Insured/Covered Member** *(Not required if Insured/Covered Member is a minor)* Name: NRIC:

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

L2CSENT

Patient's Name :
Patient's NRIC/Passport No./FIN No.:
Policy Number :

PART II MEDICAL REPORT FORM (To be completed by Attending Doctor at Insured's expense)

A) Patient's Particulars (From Hospital/Clinic's Record)	
Patient's Name:	NRIC/Passport No./FIN No.:

B) 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.			
1a. Name of hospital patient was admitted to				
1b. Hospitalisation Period	Date of admission (dd/mm/yy)	Date of discharge (dd/mm/yy)		
1c. Name of attending doctor(s)				
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) : ☐ Sleep Disturbance Disorder ☐ Physical defects from childbirth ☐ Elective cosmetic / plastic surgery ☐ Mental / Nervous Disorder ☐ Sexually transmitted disease ☐ Correction for refractive errors of ☐ Birth control / Sterilization ☐ Congenital Anomaly ☐ Infertility / Sub-fertility ☐ Impotence test / treatment ☐ HIV/AIDS related ☐ Self-destruction /intentional eye self-inflicted injuries ☐ Drug Abuse / Drug Addiction ☐ Pregnancy ☐ Childbirth ☐ Miscarriage ☐ Abortion ☐ Dental ☐ Alcoholism			
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 (dd/mm/yy)
4. Was the patient treated by any other doctor(s) for the same condition?	☐ Yes ☐ No If "Yes", please provide details.			
	Name & Address of Doctor(s)			Date of consultation (dd/mm/yy)

L4MEDRT

Patient's Name :
Patient's NRIC/Passport No./FIN No.:
Policy Number :

5. Was the patient previously treated for any other serious condition(s)?	☐ Yes ☐ No If "Yes", please provide details.

Diagnosis/Illness	Name & Address of Doctor(s)	Date of diagnosis (dd/mm/yy)

6. Was any diagnostic test(s) and/or scan(s) performed?	☐ Yes ☐ No If "Yes", please provide details below and submit a copy of the report(s).

Diagnostic Test(s)	Result(s)	Date (dd/mm/yy)

7. Were there any complications that resulted in the healing being prolonged?	☐ Yes ☐ No If "Yes", please provide details below.
8. Is there any possibility of a relapse?	☐ Yes ☐ No If "Yes", please provide details below.
9. Was the patient referred to you?	☐ Yes ☐ No If "Yes", please provide details below and furnish a copy of the referral letter.

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

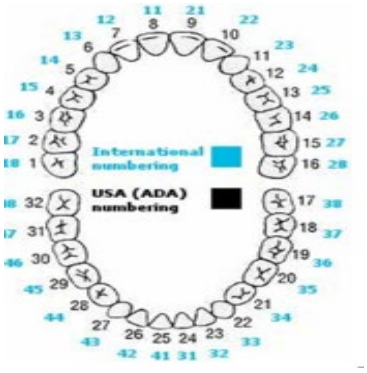
11. Are you the patient's regular doctor?	☐ Yes ☐ No If "No", please provide details below.

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

Patient's Name :
Patient's NRIC/Passport No./FIN No.:
Policy Number :

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.	Date :_____/_____/_____ (dd/mm/yy) Time:_____ am / pm		
2. Date of first consultation for this injury	Date :_____/_____/_____ (dd/mm/yy)		
3. Please describe how the accident occurred.			
4. Please describe the injuries sustained and the anatomical site involved.			
5. Please state the exact diagnosis and the date of the diagnosis of the condition.	Diagnosis	ICD 10 AM Code	Date of Diagnosis (dd/mm/yy)
6. Was the injury sustained consistent with the accident described above?	☐ Yes ☐ No If "No", please elaborate.		
7. Please state the cause of the injury.			
8 If the treatment received was as a result of a dental injury, please provide details of the injured tooth 	8a. Which tooth has been injured? _____		
	8b. Was there any existing conditions of the injured tooth prior to the accident (eg, decay, periodontal disease, and existing crown/bridge)? ☐ Yes ☐ No If yes, was it in good repair, at the time of accident? ☐ Yes ☐ No		
	8c. Please provide name and address of doctor for the treatment of injured tooth		
9. 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	

Patient's Name :
Patient's NRIC/Passport No./FIN No.:
Policy Number :

<table>
<tr><td rowspan="4">10. Was the patient suffering from any illness/infirmity which would likely have contributed to the injury or prolonged the period of disability?</td><td colspan="3">☐ Yes ☐ No If "Yes", please answer 10a - 10c.</td></tr>
<tr><td colspan="3">10a. Please provide details below.
<table><tr><th>Diagnosis</th><th>Date of diagnosis dd/mm/yy</th><th>Name & address of doctor(s) consulted</th></tr><tr><td></td><td></td><td></td></tr></table></td></tr>
<tr><td colspan="3">10b. How has the illness/infirmity contributed to the injuries or prolonged the period of disability?</td></tr>
<tr><td colspan="3">10c. What would be the usual recovery time if not for the illness/infirmity?</td></tr>
<tr><td>11. What is the period of medical leave issued?

Temporary Total Disability – The patient <u>cannot engage in each and every duties</u> of his/her usual occupation, business or activities.

Temporary partial Disability – The patient <u>can engage in one or more duties</u> of his/her usual occupation, business or activities.</td><td>Start Date
_____/ _____ / _____
(dd/mm/yy)

Start Date
_____/ _____ / _____
(dd/mm/yy)</td><td>End Date
_____/ _____ / _____
(dd/mm/yy)

End Date
_____/ _____ / _____
(dd/mm/yy)</td></tr>
<tr><td>11a. Were medical certificates issued for the above stated period?</td><td colspan="2">☐ Yes ☐ No If "No", please elaborate</td></tr>
<tr><td>12. Has the patient fully recovered from the injuries?</td><td colspan="2">☐ Yes ☐ No If "No", please elaborate.</td></tr>
<tr><td>13. Did the patient's injuries result in permanent and total loss of use of the organ or limb involved?</td><td colspan="2">☐ Yes ☐ No If "No", please state the extent of the loss of use of the limb/organ.</td></tr>
<tr><td>14. Would the injuries sustained have prevented the patient from working in his/ her occupation?</td><td colspan="2">☐ Yes ☐ No If "Yes", please explain how her/his injuries could have prevented her/him from performing all duties of his/her occupation as stated above?</td></tr>
</table>

Patient's Name :
Patient's NRIC/Passport No./FIN No.:
Policy Number :

D) Details Of Illness

1. When did the patient **first** consult you for the condition?	Date :_____/_____/_____ (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?	Date :_____/_____/_____ (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 the diagnosis of the condition.

Diagnosis	ICD 10 AM Code	Date of Diagnosis (dd/mm/yy)

6. Was the patient informed of the diagnosis?

☐ Yes If "Yes", when was the patient informed? _____ (dd/mm/yy)

☐ No

7. What was your advice to the patient?

8. What is the underlying cause of the condition diagnosed?

Underlying Condition (s)	Date of diagnosis of the underlying condition dd/mm/yy

9. Was the medical condition(s) mentioned in Q(5) require urgent remedial treatment to avoid death or serious impairment to the Insured's immediate or long term health?

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

10. Was the patient aware of the condition diagnosed prior to seeing you?

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

11. Has the patient consulted any other doctors/hospitals for the symptoms/ condition prior to the first consultation with you?

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

Name of Doctor(s)	Name & Address of the Clinic(s)/Hospital(s)	Date of Consultation dd/mm/yy

Patient's Name :
Patient's NRIC/Passport No./FIN No.:
Policy Number :

12. Has the patient fully recovered from the illness?	☐ Yes ☐ No If "No", please elaborate.
13. Are there <u>any other</u> illness(es) that would have contributed to the patient's condition?	☐ Yes ☐ No If "Yes", please answer 13a - 13c below.

13a. Please provide details.

Diagnosis	Date of diagnosis dd/mm/yy	Name & Address of doctor(s) who made the diagnosis

13b. Was the patient informed of the above diagnosis?

☐ Yes ☐ No

13c. When was the patient informed of the diagnosis?

Date :_____/_____/_____ (dd/mm/yy)

<u>IMPORTANT</u>: Kindly enclose copies of surgical reports, laboratory evidence, diagnostic test results and any other relevant hospital reports that are available.

E) Attending Doctor's Name & Signature

Name of Doctor : _____

MCR No : _____

Signature : _____

Date (dd/mm/yy) : _____

Address/Official Stamp: