



# AIA SINGAPORE AIA ASSIST / AROUND THE WORLD CLAIM FORM

Policy Number:

This printed form is forwarded on receipt of notice of a claim and its being sent is in no way an admission of claims.

**PART 1 (TO BE COMPLETED BY POLICYOWNER)**

**CLAIMANT'S PARTICULARS**

Name of Insured Person:	NRIC/FIN/Passport No:	Name of Policyowner:
Home Address:	Age: Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Insured Person:
Occupation:	Name of Employer:	Nature of Business:

**GENERAL INFORMATION**

Place, Date and Time where event occurred:
Describe the event in detail (in the case of sudden and unexpected sickness, state also the symptoms experienced and its duration. In the case of an accidental injury, state also the nature and extent of injuries sustained).
Travel Agent and/or Airline Company:
Departure Date of Insured Journey: <span style="float: right;">Arrival Date of Insured Journey:</span>
Are there any other insurance policies covering the insured person in respect of this event? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give names of insurers, policy numbers and amount recovered or recoverable:
Basic Documents Required: (a) Travel ticket/Boarding Pass (b) Copy of relevant parts of your passport and any other documents that we may require.

*Please complete the relevant benefit(s) that you are claiming:*

**PERSONAL ACCIDENT (ACCIDENTAL DEATH & PERMANENT DISABILITY)**

In the case of an accidental death, what is the official cause of death?
In the case of an accidental injury resulting in permanent disablement, has the insured person suffered this or similar condition or a recurrence of a previous injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please specify:
Date of previous injury: <span style="float: right;">Insurance Co.s Involved:</span>
Amount Claimed: <span style="float: right;">Circumstances:</span>
Name(s) and Address(es) of doctor(s) who attended to insured person
Is the insured entitled to receive compensation from any other source in respect of this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please specify:
Source of Compensation: <span style="float: right;">Amount Compensated:</span>
Documents Required: (a) Medical Report (b) Police investigation report (c) Newspaper report (if any). In the case of an accidental death, please also submit a Certified True Copy of the death certificate.



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**REPATRIATION / EMERGENCY MEDICAL EVACUATION BENEFITS**

Has the insured person contacted AIAS for assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'No', please provide reason(s):
Was the sen/ice approved and arranged by AIAS? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Exclusion No.6 &amp; 7 applicable to section 4 (Part III &amp; IV):</b>
<ul style="list-style-type: none"> <li>Any expenses for a sen/ice not approved and arranged by AIAS shall be excluded except that this exclusion shall be waived in the event that the insured person or his/her travelling companions cannot notify AIAS during an emergency medical situation for reasons beyond their control. In this case, the company reserves the right to reimburse the insured only for those expenses incurred for service which AIAS would provide under the same circumstances.</li> <li>Any expenses incurred for the transportation of insured person's remains not approved and arranged by AIAS shall be excluded.</li> </ul>

**MEDICAL EXPENSES/HOSPITAL INCOME BENEFITS**

Diagnosis made by Attending Physician:	Period of Hospitalisation:
as the insured person ever suffered this or similar condition or a recurrence of a previous illness or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please specify:
	Date of previous illness / injury:
	Insurance Co.s Involved:
	Amount Claimed:
Circumstances:	
Name(s) and address(es) of doctor(s) who attended to insured person:	
Name(s) and address(es) of insured person's usual doctor(s):	
Documents Required: (a) Original final medical bills and receipts (b) Medical Certificates (c) Medical report from doctors / dental surgeon confirming that surgery / dental treatment could not be delayed.	

**TRAVEL CANCELLATION / TRAVEL CURTAILMENT / TRAVEL POSTPONEMENT / INSOVLENCY OF TRAVEL AGENT BENEFITS**

When and where was the holiday booked?		
Reason for trip cancellation /trip curtailment:		
If cancellation /curtailment was due to death or serious accidental injury or serious sickness of an immediate family member, please state relationship to insured person:		
For <b>Trip Cancellation</b> , please provide :	For <b>Trip Curtailment</b> , please provide:	
Intended Departure Date:	Scheduled Insured Journey: From _____ to _____ (dd/mm/yy)	
Date Cancelled:	Date Insured Journey was interrupted: _____ (dd/mm/yy)	
	Date of departure from the country due to interruption: _____ (dd/mm/yy)	
Amount paid by the insured person:	Amount recovered from other sources:	Amount Claimed:
	Documents Required: (a) Birth Certificate of insured person (b) Death Certificate of insured person or immediate family member or close business partner (where applicable) (c) Medical Certificates (d) Letter from doctor confirming that it was necessary to return to Singapore (e) Letter from your travel Agent / Carrier confirming: (i) Tour was cancelled (ii)The period of cancellation & (iii) The amount refunded or evidence proof that loss is claimed or refundable by other sources.	

**FLIGHT DELAY / FLIGHT DIVERSION / FLIGHT OVERBOOKING / TRAVEL MISSED CONNECTION / BAGGAGE DELAY BENEFITS**

For <b>Flight Delay</b> , please provide :	For <b>Baggage Delay</b> , please also provide:
Original Time, Date and Place of Departure:	Time and Date the insured person arrived at destination:
Original Flight No. and Airlines / Carrier:	
Actual Time, Date and Place of Departure:	Actual Time and Date when delayed baggage were delivered to and received by insured person:
Actual Flight No. and Airlines / Carrier:	
<p>Documents Required: (a) Letter from Airlines / Carrier on the cause of delay and details to substantiate claim (b) Boarding Pass (c) Acknowledgement receipt for baggage received.</p>	

**LOSS OF BAGGAGE / LAP TOP COMPUTER (EXTENSION COVER) / GOLFING EQUIPMENT (EXTENSION COVER) / PERSONAL MONEY & TRAVEL DOCUMENTS / JEWELLERY COVERAGE BENEFITS**

**A) For items being stolen due to theft**  
 State location of Police Station where the insured person has filed the report and furnish us with a certified true copy of the report.

Date Reported:

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Has a thorough search been made and notification sent to common carrier / hotel management?  Yes  No

Date Reported:

**B) For items being lost or damaged while property in the care/ custody of common carrier (airlines, bus company etc.) or hotel**  
 Has the insured person lodged a claim or complaint against the Carrier / Airline or hotel management or other authority or against any individual responsible for the loss or damage to the property?

Yes  No

If Yes, please give details, attach copies of correspondence and advise outcome of the insured person's claim against them:

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Name of Carrier / Airline / Hotel, whichever is applicable:

**GIVE DETAILS OF ITEMS AND AMOUNT CLAIMED**

Item lost / damaged	Description (make / model & brandname)	Place & Year Purchased	Original Purchase Price	Claim Amount

Documents Required: (a) Original receipts of all items claimed (b) Proof of ownership (c) Written documentation from hotel management and/or common carrier (d) Police report

**COMPASSIONATE VISIT / HOSPITAL VISIT / CHILD PROTECTOR BENEFITS**

What is the reason for additional travel and accommodation expenses?

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Please provide description of loss

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Period of Hospitalization

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Please state their name and relationship to you

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Details of accommodation expenses and additional travel expenses

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Documents Required: (a) Attach all communication received.

**PERSONAL LIABILITY BENEFITS**

What is the name and address of the other party?
Nature of injuries sustained by the other party or extent of property damaged:
To which police officer or at which police station (if any) did the insured person report the incident?
Has a claim been made against the insured person? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, please give details and submit all relevant documents:
Name(s) and address(es) of witness(es) of the incident, if any:
<b>Documents Required: (a) Attach all communication received.</b>

**OTHERS**

In respect of any other claim, which does not fall within the sections stated above, please provide details of the claim you are submitting.
<b>Documents Required: (a) Attach all communication received.</b>

**BANK ACCOUNT INFORMATION OF POLICYOWNER**

Name of Bank	Branch of Bank	Bank Account No.	Account Holder's Name
*Signature of Policyowner _____ Date _____			
NB: Claim amount payable to policyowner (excluding reimbursement to CPF Board) up to \$10,000 will be credited directly to the above bank account. For Claim amount payable to policyowner above \$10,000, a cheque will be handed to your Financial Services Consultant/Insurance Representative for delivery.			
* Please ensure that your signature is the same as the signature on your Application Form for Policy for verification purpose.			

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



**AUTHORISATION & DECLARATION**

Patient Name: \_\_\_\_\_ Patient's NRIC/Passport no./Fin no.: \_\_\_\_\_

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 sub-clause
- (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 health 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.

I/We 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.

I/We 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.

This authorisation and declaration shall bind my/our successors and assignees, and remains valid, notwithstanding death or incapacity. I/We agree that a photocopy of this authorisation shall be effective and valid as the original.

\_\_\_\_\_  
Date: \_\_\_\_\_ Signature of Insured Person (Policyowner if Insured Person is a minor)

Note: No fees, commission or charges of whatever nature are payable to agents or employees of the Company in respect of this claim.



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