AIA SINGAPORE

PERSONAL LINES CLAIM FORM

Important Notes:

1) This printed form is forwarded on receipt of notice of a claim and its being sent is in no way an admission of claims.
2) Please ensure that you have signed the "Authorisation and Declaration" selection using the same signature as in AIA Singapore's records.

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

B) Insured/Covered Member & Policyowner's Particular		
Name of Insured/Covered Member:	NRIC/Passport No./ Fin No.:	Contact No.:
Mailing Address: (Postal Code ( )		
Present Occupation:	Company Name and Business Address:	Exact job Duties:
Name of Policyowner (if different from Insured/Covered Member):		Policyowner's Relationship To Insured:

C) Type of Benefit Claim	
1. Circumstances of Loss / Damage / Injury / Accident, kindly indicate:	i. Date of Claim ____ DD _____ MM ______YYYY ii. Where it happened? iii. How it happened?
2. For claim under In-Patient Care and Day Surgery, please complete the Certificate of Medical Attendant. 3. Please provide proof of relationship when lost item(s) belongs to immediate family members and/or proof of travel if missing item(s) is not reported in origin country of loss.	
4. Is there any other insurance coverage on the same property insured?	☐ Yes ☐ No
5. Have you ever sustained any loss or damage of the same nature?	☐ Yes ☐ No
6. Description of Loss / Damage / Injury	
7. Date Purchased	____ DD _____ MM ______YYYY
8. Price Paid	

PT0022316 (01/2016A 08/2018 09/2018)

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

D) 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.

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.

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

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.

Name & address of attending doctor(s)	Date Admitted	Date Discharged

2. Was the treatment or condition due to or listed 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 eye
☐ Birth control / Sterilization
☐ Congenital Anomaly
☐ Infertility / Sub-fertility
☐ Impotence test / treatment
☐ HIV/AIDS related
☐ Self-destruction /intentional 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

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

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

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).

Diagnosis Test(s)	Result(s)

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.

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Patient's Name :
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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 "Yes", please provide details below.	
	Name of Regular Doctor(s)	Name & Address of Clinic/Hospital

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. Please describe how the accident occurred.	
3. Please state the cause of 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.

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10. Was the patient under the influence of alcohol or drugs at the time of accident?	☐ Yes ☐ No If "Yes", please provide details below.	
	Type of Alcohol / Drug Consumed	Blood Alcohol Level / Quantity Consumed

1.Was the patient suffering from any illness/infirmity which would like 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?		

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 symptom(s) of the condition diagnosed?	Date :_______/_______/_______ (dd/mm/yy)	
4. In your opinion, how long have the symptom lasted prior to the **first** consultation with you?		
5. Please state the exact diagnosis and the date of diagnosis of the condition.	Diagnosis	Date of Diagnosis
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?		

Patient's Name :
Patient's NRIC/Passport No./FIN No.:
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<table>
<tr><td rowspan="2">9. Was the patient aware of the condition diagnosed prior to seeing you?</td><td colspan="3">☐ Yes ☐ No If "Yes", please elaborate.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="3">10. Has the patient consulted any other doctors/hospitals for the symptoms/ condition prior to the first consultation with you?</td><td colspan="3">☐ Yes ☐ No If "Yes", please provide details.</td></tr>
<tr><td>Name of Doctor(s)</td><td>Name & Address of the Clinic(s)/Hospital(s)</td><td>Date of Consultation</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td rowspan="6">11. Are there <u>any other</u> illness(es) that would have contributed to the patient's condition?</td><td colspan="3">☐ Yes ☐ No If "Yes", please answer 11a - 11c below.</td></tr>
<tr><td colspan="3">11a. Please provide details.</td></tr>
<tr><td>Diagnosis</td><td>Date of diagnosis</td><td>Name & Address of doctor(s) who made the diagnosis</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="3">11b. Was the patient informed of the above diagnosis?
☐ Yes ☐ No</td></tr>
<tr><td colspan="3">11c. When was the patient informed of the diagnosis?
Date :_______/_______/_______ (dd/mm/yy)</td></tr>
</table>

<u>IMPORTANT</u>: To enable us to proceed with the claim, 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 : ____

Address/Official Stamp:

MCR No : ____

Signature : ____

Date (dd/mm/yy) : ____