AIA SINGAPORE
AIA SUPERCHARGE TRAVEL (80287) CLAIM FORM
Corporate Solutions
3 Tampines Grande, #07-00, AIA Tampines, Singapore 528799, Email : sg.cs.campaign@aia.com

CLAIM PROCEDURES

FOR OVERSEAS MEDICAL EXPENSES DUE TO COVID-19

Please furnish the following documents within 90 days from date of incurred :-

a) Duly completed Section 1 of the Claim Form*
b) Copy of the Hospital Discharge Summary / Duly completed Section 2 of the Claim Form by the Attending Doctor*
c) Copy of Laboratory Report*
d) Copy of Covid19 Vaccination Card / Certificate*
e) Claims settlement (if payable) will be made payable to the insured member

FOR OVERSEAS QUANRANTINE ALLOWANCE DUE TO COVID-19

Please furnish the following documents within 90 days from date of quarantine discharge :-

a) Duly completed Section 1 of the Claim Form*
b) Copy of letter / documentation from Medical / Governmental Authority for Quarantine*
c) Copy of Covid19 Vaccination Card / Certificate*
d) Claims settlement (if payable) will be made payable to the insured member

FOR DEATH CLAIM DUE TO COVID-19

Please furnish the following documents within 90 days from date of death :-

a) Duly completed Section 1 of the Claim Form*
b) Mandatory duly completed Physician's Statement (including any other medical evidence) by the Attending Physician / Surgeon*
c) Copy of Death Certificate*
d) Copy of Covid19 Vaccination Card / Certificate*
e) Documentation proof of relationship to insured member*
f) 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:

☐ **Overseas Medical Expenses** ☐ **Overseas Quarantine Allowance** ☐ **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 Overseas Medical Expenses & Quarantine Allowance)					
Bank Name		Branch Code		Bank A/C No.	

Part C: Details of Admission (For Overseas Medical Expenses Benefit)			
Admission Date (DD/MM/YY)		Discharge Date (DD/MM/YY)	
Hospital Name			
Final Diagnosis after discharge			

Part D: Details of Quanrantine (For Overseas Quarantine Allowance Benefit)			
Quarantine Start Date (DD/MM/YY)		Quarantine End Date (DD/MM/YY)	
Name of Quarantine Facility			

Part E : Details of Death (For Death Benefit)			
Date of Death (DD/MM/YY)		Place of Death	
Cause of Death			

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's Statement – For Overseas Medical Expenses Benefit

To be completed by Attending Physician (The medical report fee, if any, will be borne by the Claimant)

1) Name of Patient | NRIC / Passport No.

2) Final Diagnosis of illness or extent of injury | ICD Code | ICD Code | ICD Code

3) What is the cause of illness / injury?

4) Please specify the approximate date of discovery of the illness or injury

5) How long has the illness / injury been existing prior to consulting you?

6) Did the patient have any symptoms prior to consulting you?
❒ Yes ❒ No - If "Yes", please indicate the nature of Symptoms and date Symptoms first started:

7) When did the patient first consult you for this condition?

8) Nature and Date of Treatment rendered

9) Has the patient ever had the same or similar condition / symptom? ❒ Yes ❒ No ❒ Not to my knowledge
If "Yes", please indicate when and describe

10) Has the patient had any prior treatment for this condition? ❒ Yes ❒ No ❒ Not to my knowledge
If "Yes", please state the following :-

Name of Doctor	First Consultation Date	Name of Clinic	Address

11) Admission Period

12) Name of Hospital

13) Date of surgical procedures or treatment rendered

14) Vaccine Adverse Event reported to HSA? ❒ Yes ❒ No
If "No", please indicate why

15) Describe the surgical procedures or treatment rendered. If no surgery was performed, please state treatment / medication given.

Operation Code | Operation Table

16) Were the above surgical procedures approached through the same incision / orifice? ❒ Yes ❒ No

17) Was the surgery performed for cosmetic purposes?
❒ Yes ❒ No

18) Is the condition / treatment related to :

		Yes	If "Yes", please elaborate	No
a) Congenital Anomaly / Genetic / Chromosomal Disorder	a)			
b) Psychological / Mental / Emotional Disorder	b)			
c) Dental / Gum Treatment / Oral Mucosal	c)			
d) Pregnancy / Childbirth / Infertility / Sub-fertility Condition	d)			
e) Self-inflicted Injury / Drug Addition / Alcoholism	e)			

19) Is the patient still under your care for this condition? ❒ Yes ❒ No - If "No" please give date service was terminated and furnished name and address of doctor if the patient has been referred to another doctor for follow-up.

Signature of Physician / Surgeon

Date (DD/MM/YY)

Name / Designation

Name and Address of Clinic / Hospital & Stamp

Section 2 : Physician's Statement – For Death Claim

To be completed by Attending Physician (The medical report fee, if any, will be borne by the Claimant)

Name of Deceased	Occupation	NRIC / Passport No.

1) Date of Death	2) Place at time of death
3) What was the immediate Cause of Death?	4) How long has the illness existed prior to Death?
5) Did Deceased have any symptoms prior to Death? ❒ Yes ❒ No If Yes, Date symptoms first started : Nature of Symptoms :	6) When did Deceased first consult you for this condition? Date : When did Deceased last consult you for this condition? Date :
7) When was the diagnosis leading to the cause of Death first diagnosed? Date :	8) Was Deceased informed of the diagnosis? ❒ Yes ❒ No If Yes, when was the Deceased first told? :

9) Did Deceased suffer from any other illness?

Illness	Period Of Illness	Date of Diagnosis	Date & Type of Treatment

10) Was the Death in any way partly attributed to Deceased's habits, family history, occupation OR previous diseases? ❒ Yes ❒ No
If Yes, give details :

11) Was there any predisposing caused of the deceased's death in his / her habits (use of alcohol, narcotics, etc) family history, occupation or previous sickness?

12) Name and address of all physicians who previously consulted by Deceased for the above condition.

Name of Physician	Name & Address of Clinic	Date of Attendance

I hereby declare that I was physician in attendance during the last illness of the deceased and that the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from the Company.

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