GROUP HOSPITAL & SURGICAL INSURANCE CLAIM FORM

AMERICAN INTERNATIONAL ASSURANCE COMPANY, LIMITED

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Group & Credit Life Insurance Department
1 Robinson Road, AIA Tower, #11-00, Singapore 048542 Fax : 6538 5603 / 65384340 Email : sg.eb.claims@aia.com

Part I (to be completed by the Employer)

Name of Employer ..... Policy No. .....

Name of Employee ..... NRIC/PP No. .....

Date of birth .....mm/.....dd/.....yy Sex: M / F Room & Board .....

Designation ..... Employee's email .....

Employee's commencement date of insurance .....mm/.....dd/.....yy Marital Status: S / M

.....	.....	.....	.....
Company's stamp	Employer's name/Telephone No.	Employer's signature	Date

Part II (to be completed by the Patient)

Name of Patient ..... NRIC/PP No. ..... Sex : M / F

Relationship to employee ..... Occupation ..... Date of birth ...../...../..... (mm/dd/yy)

1. If hospitalisation is due to sickness :

Diagnosis/symptoms: ..... Date/Type of operation: .....

2. If hospitalisation is due to accident, date: ..... place of accident:.....

Briefly describe what happened and state the extent of the injury .....

.....

3. Are you making a claim from other insurance companies ? Yes /No

If yes, name of insurance company..... policy number .....

(Please submit a copy of the other insurance company's claim settlement letter/payment voucher)

4. To whom should the claims amount be payable: -

☐ Giro - Employee's bank a/c: Bank: ..... Branch:..... Account no.: .....

☐ Cheque - Employee's / Employer's Name.....

5. Authorisation (to be signed by the Patient/Guardian)

I, hereby irrevocably authorise any hospital, doctor or other person who has attended to me or any member of my family to furnish American International Assurance Company, Limited or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records.

That AIA may and is hereby authorised to use and disclose any information collected or held (contained in this application or otherwise attached) to enable AIA, its associated individuals/organisations or independent third parties, within or outside Singapore, with regard to any matters pertaining to the Application/Policy including but not limited to processing this application and providing subsequent services to the Policyholder/Applicant/Insured Member/Dependent and to provide advice or information concerning products or services which AIA believes it may be of interest to the Policyholder/Applicant/Insured Member/Dependent or to communicate with any one of them for any purpose. The Policyholder/Applicant shall and shall procure that the Insured Member and Dependent shall, provide their respective consent for AIA to carry out all such disclosures and hereby specifically waives their respective right to bring a claim of any nature against AIA in respect of any abovementioned disclosure or any disclosure in the nature of disclosure described above.

I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

.....	.....
Signature of Patient/Guardian	Date

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Part III (to be completed by the Attending Doctor/Surgeon)

1. Name of Patient : .....
2. Admission date : ..... Discharge date: .....
3. Name of hospital: .....
4. Period of medical leave : From ..... to .....
5. Date of first consultation: .....
6. Presenting symptoms : .....
7. Primary diagnosis: ..... ICD Code:.....
8. Date of diagnosis: .....
9. a) Date of surgery : ..... Surgical Code:.....

   b) Surgical procedure: .....

   c) If excision was performed, please indicate the measurements of the lesion/tumor .....

   d) Were the above surgical procedures approached through the same incision/orifice? Yes ☐ No ☐

   e) Was surgery performed for cosmetic purposes? Yes ☐ No ☐
10. a) How long had the patient been troubled by symptoms prior to the diagnosis? .....

    b) In your medical opinion, how long do you think the illness existed prior to your diagnosis? .....
11. Has the patient had any prior treatment for this condition Yes ☐ No ☐

    If "Yes", state the date of treatment, name & address of doctor who treated the patient

    .....
12. Was the patient referred by another doctor? Yes ☐ No ☐

    If "Yes", please furnish the name and address of the referral doctor. .....
13. Was the above condition discovered during your investigation of his/her infertility condition ? Yes ☐ No ☐
14. Was the condition of patient due to or related to :

    a) congenital anomaly? Yes ☐ No ☐

    b) psychological, mental or emotional disorder? Yes ☐ No ☐

    c) dental/gum treatment or oral mucosal? Yes ☐ No ☐

    d) pregnancy, childbirth, sub-fertility or infertility? (Date of last menstrual period_____) Yes ☐ No ☐

Name of doctor : .....

Name & address of clinic : .....

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Signature of doctor : .....

Date : .....

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