GROUP HOSPITAL & SURGICAL CLAIM PROCEDURES

PRIVATE HOSPITAL

1. Upon admission, Patient signs the Medisave Authorisation form and pays a deposit as requested by the hospital

2. Patient must request the attending doctor/surgeon to complete Part III of this form. Expenses incurred for the completion of Part III will not be reimbursed

3. Upon discharge from the hospital, Patient has to submit :

   a) this form with all 3 parts fully completed
   b) original hospital detailed final bills/outpatient bills & receipts

GOVERNMENT / RESTRUCTURED HOSPITAL

If the claim amount does not exceed S$1,000, Patient has to submit :

a) This form with only Parts I & II completed
b) Original hospital detailed final bills/outpatient bills & receipts
c) A photocopy of the Hospital Admission Summary (if any)
d) The Discharge Summary form

If the claim amount exceeds S$1,000, Patient has to submit :

a) Original hospital detailed final bills/outpatient bills & receipts
b) This form with all 3 parts completed

- The Employer/Patient must complete Part I & II of this form respectively
- Then submit the form to the Medical Records Section of the hospital for the completion of Part III. The medical report fee will be charged.
- If the claim is payable, AIA will reimburse **$80**, subject to the maximum of "Other Hospital Services" benefit as stated in the policy schedule.

Hospital	Medical Report fee (subject to changes from the hospitals)
Singapore General Hospital	$108.28
Tan Tock Seng Hospital	$ 80.25
National University Hospital	$ 80.25
K.K. Women's & Children's Hospital	$ 96.30
Changi General Hospital	$ 80.00
Alexandra Hospital	$ 80.00
Khoo Teck Puat Hospital	$ 80.00

***Important notes** :*

1. *To enable the claim to be processed on a timely basis, please duly complete all the questions in the claim form and attach all the required documents.*
2. *The claim will be returned if the required documents are not provided together with this form.*

AIA SINGAPORE
GROUP HOSPITAL & SURGICAL INSURANCE CLAIM FORM

Corporate Solutions
3 Tampines Grande, AIA Tampines #07-00, Singapore 528799, Fax: 6538 5603 / 6538 4340 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 Plan Type …… Room & Board ……..……

Date of Employment ……..… mm/ …… dd/ …… yy Designation ….....

Employee's email …… Marital Status: Single / Married

Employee's commencement date of insurance ……..mm/…….dd/……yy

.....	.....	.....	.....
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, please provide:

Date: ……mm/ ……dd/ ……..yy. 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. Declaration and Authorisation (to be signed by the Patient/Guardian)

I/we, hereby authorise, agree and consent to:

a) persons and organisations, 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/organisations, 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/organisations, 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 (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 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. This authorisation shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not my/our Application/form is accepted by AIA Singapore. A photocopy of this authorisation shall be valid and effective as the original."

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

G5110000

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 : .....

.....

Signature of doctor : .....

Date : .....