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Inpatient/Day Surgery

Claim Form

Policy No.

❑ Inpatient Claim/Day Surgery Claim ❑ Health Cash Claim ❑ Special Grant Claim (For SmartCare Policy only)
❑ Maternity ❑ Pre-Hospitalisation Claim ❑ Post-Hospitalisation Claim

A. Employer (For Group Policy)

Full Name

B. Policyholder's (For Individual Policy) / Employee's (For Group Policy) Particulars

Full Name		
NRIC / FIN / Passport No.	Date of Employment	
Date of Birth (DD/MM/YYYY)	Nationality	Gender: ❑ Male ❑ Female
Contact Number (Mobile)	Email	

C. To be completed by Employer (For Group Policies)

Company Name	Plan No. / Plan Type
Date of Employment (DD/MM/YYYY)	Designation / Grade of Employee
Effective date of coverage (DD/MM/YYYY)	

D. Patient's Particulars (if Patient is a dependent of the Policyholder / Employee)

Full Name	
Relationship ❑ Spouse ❑ Child	NRIC / FIN / Passport No.
Date of Birth (DD/MM/YYYY)	Gender: ❑ Male ❑ Female

Is the Dependent: ❑ Employed ❑ Not Employed ❑ Enlisted in National Service

If employed, please furnish the name of his / her Employer:_____

E. Please complete if Inpatient / Day Surgery was due to Accident (if applicable)

Date of Accident (DD/MM/YYYY)	Time of Accident	
Place of Accident		
Describe how the accident happened (please enclose a copy of the police report, if any)		
Describe in details the injuries sustained, indicating the part of the body injured and the type of injury (eg. fracture, cut, bruise etc.)		
Was it work related? ❑ Yes ❑ No	Are you entitled to claim against Workmen Compensation? ❑ Yes ❑ No	
Date of 1st Treatment	Date of Admission	Date of Discharge
Name of hospital / clinic	Name and address of attending physician	

F. Please complete if Inpatient / Day Surgery was due to Illness (if applicable)

Nature of sickness (describe the symptoms suffered)

Date symptoms first started (DD/MM/YYYY)	Date of first consultation with a doctor for this condition (DD/MM/YYYY)

Has the patient ever seen a doctor for any similar conditions in the past? ❑ Yes ❑ No

Name of Doctor _____

Address of Doctor / Hospital _____

Name and address of regular / family doctor of Patient _____

G. Please provide these additional information if Inpatient / Day Surgery was outside Singapore (if applicable)

Purpose of the overseas trip

Date of departure and return to Singapore / own area of cover (please provide proof of travel eg. flight details / passport copy)

From _____ To _____

H. If you are making a special Grant Claim (Not applicable for International Exclusive Policies)

Date of Death (DD/MM/YYYY)	Place of Death (please specify name of hospital if death occurred in hospital)

Cause of Death

I. Other Information

Have you claimed or do you intend to claim from any insurer, other employer or any parties for reimbursement of your medical bills? ❑ Yes ❑ No

If "Yes", please state the party that you are claiming from and submit a copy of the settlement letter or payment voucher from the other party.

_____

Note: It is important that you inform us if you are claiming from another insurer, other employer or any other parties for the same bill(s). You can only be reimbursed once for the amount that you have incurred regardless of the number of medical insurance policies you may have. We reserve that right to recover if there is any excess amount paid to you.

Are you claiming for cash benefit for your Inpatient claim? ❑ Yes ❑ No

Note: This benefit is payable provided we do not bear the cost of your Inpatient claim.

J. Payment Details

1. Benefits should be made payable to

❑ Policyholder / Employer ❑ Claimant / Employee ❑ Third Party (for International Exclusive Policy only)

2. Payment is to be made by

❑ PayNow IC/FIN No. _____ Mobile No. _____ UEN _____

❑ GIRO* ❑ Overseas Telegraphic Transfer (for selected policies only)*

*Please complete section below on bank details

Name of Bank		
Name of Account Holder		
Bank Code	Branch Code	Account Number
Bank Address		
IBAN / SWIFT Code		

K. Declaration and Authorisation (this part must be signed by patient or patient's parent / legal guardian if patient is below 17 years of age

I/We confirm that I am/We are the claimant and/or the Policyholder and I/We declare that all the statements and answers stated are true and complete to the best of my/our knowledge and belief.

I/We hereby authorise AXA Insurance Pte Ltd ("AXA") to request from any physician, hospital, dentist, person or organisation (including the Policyholder (the "Employer"), all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment and copies of all hospital and medical records concerning me/us and/or my dependents (where applicable) at any time and authorise the prior mentioned organisations to disclose all such information to AXA. A photocopy of this authorisation shall be considered as effective and valid as the original.

In connection with my/our claim, I/We give consent for AXA Insurance (collectively "AXA") and their respective representatives or agents to collect, use, store, transfer and/or disclose the information (including that provided by sources other than myself) concerning me/us and/or my dependents to or with all such persons (including any member of the AXA Group or any third party service provider, and whether within or outside of Singapore and the Policyholder when claiming under a Group Policy) for the purpose of enabling AXA to provide me/us and/or my dependents (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/or managing my/our claims or the Employer's Group Policy(ies) with AXA (as the case may be), and for the purposes set out in AXA's Data Use Statement which can be found at http://www.axa.com.sg ("Purpose").

Full Name, NRIC / FIN / PP no. & Signature of Claimant / Employee (Parent's or Guardian's signature if patient is a minor)	Full Name, NRIC / FIN / PP no. & Signature of Patient (Parent's or Guardian's signature if patient is a minor)
Date (DD/MM/YYYY) _____	Date (DD/MM/YYYY) _____