AXA INSURANCE SINGAPORE PTE LTD
143 Cecil Street #01-01 GB Building
Singapore 069542
Tel: (65)6338 7288 Fax: (65)6338 2522
Internet: www.axa.com.sg
Co. Reg No. 196900406D

H & S CLAIM FORM

Please answer in full all the applicable questions on this side of the form only and attach documentary proof of illness/original bills which are eligible for benefits. **Incomplete answers may delay claims settlement.**

Any interest charged by hospitals will be borne by the employer/member if the full claim requirements are not received within 30 days from the date of discharge. **Claims submitted later than 30 days of the expenditure being incurred may be declined for the benefit payment.**

* Mandatory Fields

I. DETAILS OF INSURED AND PATIENT (Please give us information about yourself.)

*Name of Policyholder:	*Address of Policyholder: Contact No.:
*Name of Insured Person/Employee:	*NRIC/Passport No./FIN No.: Date of Birth: DD MM YYYY Sex: ☐ Male ☐ Female Marital Status:
*Policy No.:	*Type of Plan (for group policy):
*Occupation:	*Date employment commenced: DD MM YYYY

*Patient is ☐ Self ☐ Spouse ☐ Child

If patient is your dependant, please provide information below.

*Name of Patient (i.e. Insured Dependant):	*NRIC/BC/Passport No./FIN No.: Date of Birth: DD MM YYYY Sex: ☐ Male ☐ Female

II. DETAILS OF ILLNESS OR INJURY (Please complete 1 or 2.)

1a. Nature of Illness/Diagnosis:	
1b. What were the symptoms experienced by the patient	
1c. Date when symptoms were first noticed by the patient:	DD MM YYYY
1d. How long have the patient been troubled by the symptoms?	
1e. Has the illness been treated before?	☐ Yes ☐ No
1f. Date of first consultation with a medical practitioner for this condition:	DD MM YYYY
1g. Name and address of medical practitioner consulted for the above condition(s)	
1h. Name and address of patient's regular medical practitioner (other than the one name above)	
1i. Is this treatment related to pregnancy, childbirth, abortion or miscarriage?	☐ Yes ☐ No

Please complete the following (Question 2a to 2d) if you have sustained injury as a result of an accident.

2a. Describe the injury and how it occurred:	
2b. When and where did the injury occur?	DD | MM | YYYY Place:
2c. When and where did the first consultation for this injury take place?	Place:
2d. Is this a job-related injury?	☐ Yes ☐ No

III. OTHER INFORMATION

1. Name of Hospital/Clinic:	
2. Date admitted:	DD | MM | YYYY
3. Date surgery performed:	DD | MM | YYYY
4. Date discharged:	DD | MM | YYYY
5. Are you eligible to claim for this treatment against any other insurance policies?	☐ Yes ☐ No

If Yes, please state insurance company : _____

Type of Policy: _____ Policy No.: _____

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

6. Benefit cheques should be payable as follows **(Please tick on the boxes provided)**
(Note: All benefit cheques will be made payable to POLICYHOLDER unless indicated otherwise.)

☐ Insured Person/Member _____ ☐ Employer _____ ☐ Medisave _____

MEDICAL INFORMATION AUTHORITY

(This part must be signed by patient or patient's parent/legal guardian if patient is below 21 years of age.)

Name of Patient: _____ NRIC/Passport No.: _____

Hospitalisation Period: From _____ To _____

I, _____ NRIC/Passport No. _____ hereby authorise any hospital, physician or any other person who has attended to or examined me/my child/my _____ (patient named above, please specify relationship), or is authorised to maintain medical records, to disclose when requested to do so by AXA Insurance Singapore Pte Ltd any and all information with respect to any illness or injury, medical history to treatment. A photocopy of this authorisation shall be considered as effective and valid as the original.

I HEREBY DECLARE that I warrant the truth of the foregoing particulars in every respect, and I agree that if I have made, or if I shall make, any false or untrue statement, suppression or concealment, the Policy shall be void and all rights to compensation shall be absolutely forfeited.

Signature of Patient or Legal Representative

_____

Date

Verified and witnessed by employer (for group member)

_____

Signature and Company's Stamp

Date

MEDICAL CERTIFICATION OF TREATMENT

SPECIAL INSTRUCTION:
(GROUP SCHEME MEMBERS): Please arrange for this Medical Certification of Treatment to be completed by your treating doctor if you have attended a Private Hospital or Hospital outside Singapore.

(INDIVIDUAL SCHEME MEMBERS): Please arrange for this Medical Certification of Treatment to be completed by your medical practitioner for treatment in all hospitals.

1. Name of patient:	**NRIC:**
2. Full description of diagnosis (based on ICD, 1975 revision, WHO) a) Principal diagnosis: b) Other diagnosis:	 ICD CODE ☐☐☐☐ ICD CODE ☐☐☐☐
3. What is the cause of the illness/injury? _____	
4. Has the patient suffered or is sufering from any other medical condition(s) that is/are related to the diagnosis in Question 2? If yes, please give details & when the condition(s) manifested. _____ _____	☐ YES ☐ NO
5. Is this treatment related to: i) Sleep Apnea ii) Obesity iii) Weight Reduction/Improvement	☐ YES ☐ NO
6. Is this treatment related to a) pregnancy or childbirth? b) abortion or miscarriage? If related to miscarriage, was it due to accident?	 ☐ YES LMP: ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO
7. Will the patient be required to undergo a) Normal Delivery b) Elective Caesarean If Elective Caesarean, please state the reason. _____ _____	 ☐ YES ☐ NO ☐ YES ☐ NO
8. Is this treatment a) related to infertility/subfertility condition? b) done to correct infertility/subfertility condition?	 ☐ YES ☐ NO ☐ YES ☐ NO
9. Is this due to self-inflicted injury or sexually transmitted disease?	☐ YES ☐ NO
10. Is this condition a) a congenital anomaly? b) a mental or nervous disorder? c) a refractive error of the eye?	 ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO

11. Is this a) a cosmetic surgery? If No, Please explain_____ b) an oral surgery? c) a dental surgery/treatment?	☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO
12. Is this a job-related injury?	☐ YES ☐ NO
13. Has the patient ever had the same or similar condition / symptoms? If yes, please indicate when and describe.	☐ YES ☐ NO
14. Doctors previously consulted by the patient for the above condition(s).	
15. Please indicate approximate date from which the patient first notice symptoms of condition.	DD | MM | YYYY
16a. What symptoms did the patient present?	
16b. How long had the patient been troubled by them?	DD | MM | YYYY
17. Date you were first consulted for this condition.	
18a. Date of diagnosis for this condition. **18b. Date patient was informed of your diagnosis**	DD | MM | YYYY DD | MM | YYYY
19. How long had has the injury / illness been existing prior consulting you?	

20. Surgical operations performed on patient

*Operation Code	Type of Operation	*Table	Date Performed
☐☐☐☐☐☐	_____	_____	DD | MM | YYYY
☐☐☐☐☐☐	_____	_____	DD | MM | YYYY
☐☐☐☐☐☐	_____	_____	DD | MM | YYYY

_____
Date

_____
Signature of Physician/Surgeon and Official Stamp.

Name of Physician/Surgeon
Address

* This applies to operations carried out in S'pore only and refers to the classification in the Medisave table of surgical operations for private hospital.