

GROUP HOSPITAL & SURGICAL CLAIM PROCEDURES

PRIVATE OR OVERSEAS 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

SINGAPORE 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. A medical report fee will be charged.
 - If the claim is payable, AIA will reimburse \$50, subject to the maximum of "Other Hospital Services" benefit as stated in the policy schedule.

<u>Hospital</u>	<u>Medical Report fee</u> (subject to changes from the hospitals)
Singapore General Hospital	\$78.75
Tan Tock Seng Hospital	\$75.00
National University Hospital	\$75.00
K.K. Women's & Children's Hospital	\$75.00
Changi General Hospital	\$75.00
Alexandra Hospital	\$75.00

Note : The claim will be returned if the required documents are not provided together with this form.

American International Assurance Company, Limited

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“GROUP HOSPITAL & SURGICAL INSURANCE CLAIM FORM”

Part I (to be completed by the Employer)

Name of Employer Policy No.
 Name of Employee Designation
 Date of birth (mm/dd/yy) Marital Status: S / M NRIC/PP No.
 Date of employment (mm/dd/yy)..... Sex: M / F Room & Board
 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, date & time: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. 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. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

.....
 Signature of Patient/Guardian Date

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 :