redefining / insurance

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# Inpatient/Day Surgery Claim Form

**Policy No.**

☐ Inpatient Claim/Day Surgery Claim ☐ Health Cash Claim ☐ Special Grant Claim (For Smart Care Policy only)

## 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 Birth (DD/MM/YYYY) Gender ☐ Female ☐ Male

Email Address

Contact Number (Home/Office) Mobile

## C. Patient's Particulars (If Patient is a dependent of the Claimant/Employee)

Full Name

Relationship ☐ Spouse ☐ Child NRIC/FIN/Passport No

Date of Birth (DD/MM/YYYY) Gender ☐ Female ☐ Male

## D. 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 injury(s) 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 Work Injury Compensation? ☐ Yes ☐ No

## E. 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

## F. 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

From To

## G. Please complete if you are making a Special Grant claim (For Smart Care Policy only)

Date of death (dd/mm/yyyy)

Place of death

(Pls specify name of hospital if death occured in hospital)

Cause of death

## H. 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? (For International Exclusive Policy) ☐ Yes ☐ No

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

## I. To be completed by employer ( Applicable for Smart Care Headcount Policy only)

Date of employment (DD/MM/YYYY) Effective date of coverage (DD/MM/YYYY) Plan No.

Company Name

Signature of Employer and Company Stamp

Date (DD/MM/YYYY)

## 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

☐ Cheque ☐ Direct Credit (For International Exclusive Policy only)

☐ Overseas Telegraphic Transfer (For International Exclusive Policy)

Name of Bank _____ Name of Account Holder _____

Bank Code _____ Branch Code _____ Account Number _____

**For overseas telegraphic transfer, please provide these additional information**

Bank Address _____

IBAN/SWIFT Code _____

## K. DECLARATION, AUTHORIZATION & CUSTOMER'S DATA PRIVACY CONSENT

*[Declaration]* I/We confirm that I am/We are the claimant and/or the Policyholder and I/We declare that all the particulars given above are to the best of my/our knowledge true and correct.

[Authorization] I / We hereby consent to and authorize the medical practitioner involved in the claimant's care to discuss and disclose treatment details and discharge arrangements with and to AXA Insurance Pte Ltd. I/We agree that a copy of this consent shall have the validity of the original.

[Customer's Data Privacy Consent] In connection with my/our and/or the claimant's claims, I/We give consent for AXA Insurance Pte Ltd ("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 the claimant, 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 and their respective representatives or agents to provide me/us and/or the claimant (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/or managing my/our and/or the claimant's claims or the Policyholder 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 ("Purposes").

_____ _____

Signature of Claimant/Employee
(Parent's or Guardian's signature if patient is a minor)

Signature of Patient
(Parent's or Guardian's signature if patient is a minor)

Date (DD/MM/YYYY) _____ Date (DD/MM/YYYY) _____

## L. TRACK YOUR CLAIM STATUS

Should you have any query on your claim status,please contact us at the following

www.axa.com.sg (File a Claim)
1800 880 4888
(65)6322 2555
customer.care.health@axa.com.sg (Smart Care Policy)
ops@ipa.sg (International Exclusive Policy)

AXA Insurance is committed to making your claim submission simple and easy.

Thank you for insuring with AXA Insurance, we are proud to serve you.