To: Health Operations Team/Health Claims Team/ Employee Benefits (EB) Claims team
**AXA Insurance Pte Ltd**

| **AUTHORISATION DECLARATION** | |
|---|---|
| Patient's Name: | |
| Patient 's NRIC/FIN/Passport: | |
| Claimant's Name: | |
| Claimant's mobile number: | |
| Policy Number: | |
| Relationship to Patient: | |

I confirm I am the patient / patient's parent / patient's spouse / patient's legal guardian* (circle where applicable) and wish to claim under the above policy and I declare that the statements stated are true and complete to the best of my knowledge and belief.

I hereby authorize AXA Insurance Pte Ltd and its representative(s) to request from any physician, hospital, dentist, person or organization (including the Policy Owner (the "Employer"), all information with respect to any illness, injury, medical history, consultations, billing information, prescriptions or treatment and copies of all hospital and medical records concerning me and/or the patient at any time and authorize the prior mentioned organizations to disclose all such information to AXA Insurance Pte Ltd and its representative(s). A photocopy of this authorization shall be considered as effective and valid as the original.

In connection with my and/or the patient's claims, I give consent for AXA Insurance Pte Ltd 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 and/or the patient, 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 Employer when claiming under a Group Policy) for the purpose of enabling AXA Insurance Pte Ltd and their respective representatives or agents to provide me and/or the patient (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/ or managing my and/or the patient's claims or the Employer's Group Policy(ies) with AXA Insurance Pte Ltd (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").

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Signature of Patient/ Patient's Parent/ Patient's Legal Guardian* (circle where applicable)

Date: (DD/MM/YYYY)

**Please delete accordingly. To be signed by Parent of Insured or Legal Guardian of Insured if the Insured is below 21 years of age.*