

ACCIDENT AND HOSPITALISATION CLAIM / HEALTHSHIELD CLAIM PROCEDURE

DOCUMENTS REQUIRED

If this is a First Claim (i.e. first claim for an accident or illness)

1. Accident & Hospitalisation Claim Form
2. **Original** Final Bills and Receipts (photocopy or interim bills are not acceptable)
3. Copy of Detailed Inpatient Discharge Summary and any medical or diagnostic reports, if available
4. Copy of the Police Report or Accident Report, if available
5. Copy of the claim settlement letter and payment voucher if there was a reimbursement from another Insurer/ Employer
6. Copy of the Medical Leave Certificate (MC) for claims on Weekly Indemnity/Temporary Disability Indemnity Benefits 7. Clinical Abstract Application Form
8. Part II Certificate of Medical Attendant of the Accident & Hospitalisation Claim Form (Please refer to Important Notes (b) below)

If this is a Follow-Up Claim (i.e. further submission to a previous claim)

1. Follow-Up Claim Form (Please refer to Important Notes (c) below)
2. **Original** Final Bills and Receipts (not photocopy or interim bills)
3. Copy of the claim settlement letter and payment voucher if there was a reimbursement from another Insurer / Employer
4. Copy of the Medical Leave Certificate (MC) if claiming under Weekly Indemnity/Temporary Disability Indemnity Benefit

IMPORTANT NOTES

- (a) AIA HealthShield Gold claims for Singaporeans and Permanent Residents must be submitted electronically via the medical institutions at the time of admission/discharge.
- (b) The Follow-Up Claim Form is only applicable for follow-up submission to a previous claim e.g. post- hospitalisation expenses, additional medical leave certificate, etc.
- (c) All documents submitted must be in English. Any document that is not in English must be accompanied by an English translated copy of the document made by a certified translator/interpreter.
- (d) All forms must be duly completed and signed to avoid delay in claim processing. Please indicate "N.A." for fields which are not applicable.

SUBMISSION OF DOCUMENTS

All claims required documents can be submitted to AIA Singapore. You may submit the claim application together with all of the requirement to AIA Singapore in any of the following way:

- By postal mail to AIA Singapore Claims Department at
AIA Singapore Claims Department
3 Tampines Grande #09-01
Singapore 528799
Attention: Claims Department (Individual Life & Health)
- Contact your AIA Servicing Agent to assist you.

Submit your claim application in person at AIA Singapore Customer Service Centres

- **Finlayson Green at 1 Finlayson Green, Singapore 049246**
Operating Hours: Mondays to Fridays 8.45am to 5.30pm excluding Public Holidays
- **AIA Tampines at 3 Tampines Grande, Singapore 528799**
Operating Hours: Mondays to Fridays 8.45am to 5.30pm excluding Public Holidays





AIA SINGAPORE ACCIDENT & HOSPITALISATION CLAIM FORM / HEALTHSHIELD CLAIM FORM

Important Notes:

- 1) AIA HealthShield Gold claims for Singaporeans and Permanent Residents must be submitted electronically via the medical institutions at the time of admission/discharge.
- 2) Please submit Inpatient Discharge Summary, **Original** Final Bills and Receipts (photocopy or interim bills are not acceptable).
- 3) For Accident Claims, please submit a copy of the Medical Leave Certificate (MC) if you are claiming for Weekly Indemnity Benefit.
- 4) Please ensure that you have signed the "Authorisation and Declaration" selection using the same signature as in AIA Singapore's records.
- 5) You may visit our website (<http://www.aia.com.sg/en/index.html>) for the claim submission procedures.

PART I (To be completed by Insured or Policyowner if Insured is a minor)

A) Policy		
Policy Number(s) (Please indicate the policy number for the benefit(s) you would like to claim):		
B) Cause of Claim		
<input type="checkbox"/> Accident	 *L1ACCFM*	
<input type="checkbox"/> Illness	 *L1HOSFM*	
Is mandatory to select the cause of claim. Tick one box only.		
C) Insured/Covered Member & Policyowner's Particulars		
Name of Insured/Covered Member:	NRIC/Passport No./FIN No.:	Contact No.:
Mailing Address: (
		Postal Code ()
Present Occupation:	Company Name & Business Address:	Exact Job Duties:
Name of Policyowner (if different from Insured/Covered Member):		Policyowner's Relationship to Insured:
D) Payment Methods		
<input type="checkbox"/> Direct credit to my designated Singapore Dollars (SGD) bank account in Singapore. <i>If the information is incomplete or if the payee is trustee, a cheque will be issued and mailed directly to Policyowner.</i>		
Name of Bank	Branch of Bank	Bank Account No.

E) General Information & Details Of Other Insurance

1. Did the Insured submit a claim with another insurance Company or Third Party?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please complete the following and submit a copy of the claim settlement letter or payment voucher.		
	Name of Insurance Company/ Third Party	Amount (SGD)	Policy No.

F) Type Of Benefit Claim

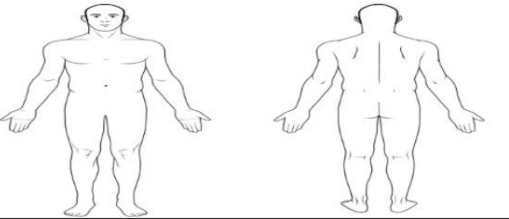
Please select the type of benefit(s) you wish to claim:

Tick	Type Of Benefit Claim	Supporting Document
<input type="checkbox"/>	Medical Reimbursement Benefit (non-Traditional Chinese Medicine)	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. A copy of valid pass (for non Singapore Citizen or non Permanent Resident) 3. Original final bill/tax invoice/receipt(s) 4. Detailed breakdown dates and charges for physiotherapy sessions 5. Certified true copy of valid pass (for Non-Singapore Citizen and non-Singapore PR)
<input type="checkbox"/>	Traditional Chinese Medicine Benefit (<i>only for accident, cancer, stroke</i>)	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Original final bill/tax invoice/receipt(s) 3. Detailed breakdown dates and charges for Traditional Chinese Medicine sessions 4. Certified true copy of valid pass (for Non-Singapore Citizen and non-Singapore PR)
<input type="checkbox"/>	Pre / Post Hospitalisation Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Original final bill/tax invoice/receipt(s) 3. Detailed breakdown dates and charges for physiotherapy sessions
<input type="checkbox"/>	Extended Post Hospitalisation Treatment for 30 Critical Illnesses Benefit	1. Duly signed and completed Accident & Hospitalisation Claim Form Part I and Part II 2. Original final bill / tax invoice/receipt(s) 3. Histopathology report / relevant diagnostic test report
<input type="checkbox"/>	Hospital Income/ Hospital Care Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. A copy of the final hospital bill with the admission and discharge date 3. Inpatient discharge summary / clinical summary 4. Certified true copy of valid pass (for Non-Singapore Citizen and non-Singapore PR)
<input type="checkbox"/>	Weekly Indemnity Benefit (This benefit is only for accident claim)	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. A copy of Medical Certificates (MC)
<input type="checkbox"/>	Fracture Benefit (This benefit is only for accident claim)	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. A copy of the X-ray/MRI/CT scan reports pertaining to the fracture injury sustained.
<input type="checkbox"/>	Mobility Aids Benefit (This benefit is only for accident claim)	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Doctor's memo/ written prescription stating the reason for purchase of mobility aid 3. Original tax invoice/receipt(s)
<input type="checkbox"/>	Recuperation Benefit (This benefit is only for Hand, Foot and Mouth Disease and dengue)	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Certified true copy of valid pass (for Non-Singapore Citizen and non-Singapore PR)
<input type="checkbox"/>	Ambulance Service Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I 2. Original final bill/tax invoice/receipt(s)
<input type="checkbox"/>	Post Hospitalisation Home Rest Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. A copy of Medical Certificates (MC)
<input type="checkbox"/>	Living Organ Donor Transplant Benefit	1. Completed Accident & Hospitalisation Claim Form, Part 1 and Part 2. Authorisation & Declaration form signed by living organ donor 3. Original final bill/tax invoice/receipt(s) of living organ donor 4. Certified true copy of valid pass (for Non-Singapore Citizen and non-Singapore PR)

<input type="checkbox"/>	Emergency Overseas (outside Singapore) Medical Treatment Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Original final bill/tax invoice/receipt(s) 3. Certified true copy of valid pass (for Non-Singapore Citizen and non-Singapore PR) 4. Inpatient Discharge Summary / clinical summary 5. A copy of all diagnostic test reports
<input type="checkbox"/>	Emergency Outpatient Treatment Accident Benefit (This benefit is only for accident claim)	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Original final bill/tax invoice/receipt(s) 3. Certified true copy of valid pass (for Non-Singapore Citizen and non-Singapore PR)
<input type="checkbox"/>	Immediate Family Member Accommodation Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Original final bill/tax invoice/receipt(s) 3. Certified true copy of valid pass (for Non-Singapore Citizen and non-Singapore PR) 4. Doctor's memo (physician/ Specialist's advice in writing on reason the immediate family member should accompany the insured)
<input type="checkbox"/>	Post – Hospitalisation Home Nursing Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Original final bill/tax invoice/receipt(s) 3. Certified true copy of valid pass (for Non-Singapore Citizen and non-Singapore PR) 4. Doctor's memo (Physician / Specialist's advice in writing on reason for home nursing care)
<input type="checkbox"/>	Pregnancy Complication Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Original final bill / tax invoice/receipt(s) 3. Certified true copy of valid pass (for Non-Singapore Citizen and non-Singapore PR)
<input type="checkbox"/>	Congenital Abnormalities of Insured Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Original final bill / tax invoice/receipt(s) 3. Certified true copy of valid pass (for Non-Singapore Citizen and non-Singapore PR)
<input type="checkbox"/>	Congenital Abnormalities of Insured's Biological Child Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. Original final bill / tax invoice/receipt(s) 3. Certified true copy of valid pass (for Non-Singapore Citizen and non-Singapore PR) 4. Child health booklet
<input type="checkbox"/>	Accidental Dismemberment Benefit	1. Duly signed and completed Accident & Hospitalisation claim form Part I and Part II 2. A copy of the X-ray/MRI/CT scan reports pertaining to the fracture injury sustained.

G) Details Of Accident

1. State the date, time and the place where the accident occurred.	Date of accident dd/mm/yy	Time of accident	Place of accident
	(dd/mm/yy)	am / pm	
2. Describe how the accident occurred			
3. Was a police report filed?			
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enclose a copy of the police report			
4. Describe the injuries sustained. Please state part of the body			

		
5. State the type of treatment(s) provided.		
6. If the treatment received was as a result of a dental injury, please provide details of the injured tooth	6a. Which tooth has been injured?	
	6b. Was there any existing conditions of the injured tooth prior to the accident (eg, decay, periodontal disease, and existing crown/bridge)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was it in good repair, at the time of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	6c. Please provide name and address of doctor for the treatment of injured tooth	
7. Name and address of the doctor(s) consulted for the injury(ies) and the date(s) of consultation.	Name & Address of Doctor(s) consulted for injury(ies)	Date of Consultation dd/mm/yy
8. Name and address of the regular / company / family doctor(s)		
9. Have the insured been given hospital/medical leave?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", please provide a copy of medical certificate.</i>	
10. Did insured submit medical certificate to employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Has the Insured returned to work?	<input type="checkbox"/> Yes If "Yes", when did the Insured return to work? _____ (dd/mm/yy)	
	<input type="checkbox"/> No If "No", when is the Insured expected to return to work? _____ (dd/mm/yy)	
12. Is the Insured able to perform all work duties after the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "No", please answer 12a. and 12b.</i>	
	12a. What are the work duties that the Insured is unable to perform?	
	12b. When is the Insured expected to fully perform all work duties?	

H) Details Of Illness

1. State the periods of hospitalisation	Period of hospitalisation		
	Date of hospital admission: (dd/mm/yy)	Date of hospital discharge: (dd/mm/yy)	
2. Details of doctor and hospital admitted for this illness	Name of doctor	Name of admitted hospital	
3. Exact diagnosis made on the Insured.			
4. Date of diagnosis first established. (dd/mm/yy)			
5. When the symptom first started? (dd/mm/yy)			
6. Describe the symptom(s) experienced.			
7. Please provide the name and address of the doctor(s) consulted for the illness or symptoms and the date(s) of consultation.	Name & Address of Doctor(s)	Illness/Symptoms	Date of Consultation dd/mm/yy
8. Name and address of the regular / company / family doctor(s)	Name & Address of Doctor(s)		
9. Was surgery performed?	Name & Address of Doctor(s)/Hospital(s)	Name of Surgery	Date of Surgery dd/mm/yy
10. Please state the information of living organ donor (If the donor is not the life insured)			
10a. Name of Living Organ Donor			
10b. NRIC / FIN of the Living Organ Donor			
10c. Is the donor has any insurance coverage that covered living organ donor expenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details		
	Name of Insurer		Policy number

Patient's Name :
Patient's NRIC/Passport No./FIN No.:
Policy Number :



I) Authorisation And Declaration

Patient Name: _____ **Patient's NRIC/Passport no./Fin no.:** _____

1. I/We, acknowledge and accept that the furnishing of this form, or of any forms supplemental thereto, by AIA Singapore Private Limited ("AIA Singapore") (Reg. No. 201106386R) is neither an admission that there was any insurance in force on the life in question, nor an admission of liability nor a waiver of any of its rights or defenses.

2. I/We:
- (a) hereby declare that I/we are duly authorised to make this claim and all statements and responses whether on this form or otherwise together with any required questionnaire, amendments, materials and supporting documents submitted in connection with the claim and the Policy ("Information");
 - (b) declare that all Information is complete, true and correct and that no information or materials have been withheld and that AIA Singapore will rely and act on the Information accordingly. Otherwise, AIA Singapore shall be at liberty to deny liability or recover amounts paid, whether wholly or partially;
 - (c) acknowledge and accept that AIA Singapore shall be at liberty to deny liability or recover amounts paid, whether wholly or partially, if any of the Information is incomplete, untrue or incorrect in any respect or if the Policy does not provide cover on which such claim is made; and acknowledge and accept that AIA Singapore expressly reserves its rights to require or obtain further information as it deems necessary.

3. I/We hereby authorise, agree and consent to:
- (a) persons and organizations, whether within or outside Singapore, including but not limited to medical sources, hospitals, doctors, other healthcare professionals, laboratories, regulator, dispute resolution centres and insurers, their associated persons/organizations, my/our or the insured person's employers or financial service providers, or their third party service providers or representatives (collectively "**Third Parties**") disclosing and releasing to AIA Singapore, its associated persons/organizations, its and their third party service providers and its and their representatives, whether within or outside Singapore (collectively "**AIA Persons**"), any information concerning the policy owner and the insured person(s) at any time, including all personal data and information, medical information, medical history, consultation history and notes, prescriptions, treatments, descriptions of medical services rendered, and any employment and financial information, including the taking of copies of such records (collectively "**Personal Data**"), relevant for the Purpose (defined below);
 - (b) the AIA Persons sharing the scope of the sub-clause (a) above, along with any of the Personal Data, with any relevant Third Parties to procure their disclosure and release of additional relevant Personal Data for the Purpose;
 - (c) the AIA Persons, including their approved medical examiners or laboratories, performing any necessary medical assessments and examinations and tests to determine, assess and evaluate the health of the insured person(s);
 - (d) the AIA Persons collecting, using, disclosing, storing, retaining and/or processing (collectively, "**Using**"/"**Use**") the Personal Data for the Purpose; and
 - (e) waive any right (on my own behalf and on behalf of the insured person(s) where applicable, in respect of which I/ we represent and warrant that the insured person(s) have granted me/us authority to so waive) to bring a claim of any nature against any of the AIA Persons in respect of any above-mentioned Use and/or any Use of any Personal Data for the Purpose.

Where I/we are not the insured person, I/we represent and warrant that I/we have obtained the consent of the insured person(s), except to the extent such consent is not required under relevant laws: (i) to collect their Personal Data; (ii) to disclose their Personal Data to the AIA Persons; and (iii) for the AIA Persons and Third Parties to Use any of their Personal Data in the manner and for the purposes described in this Clause. I/We hereby agree to indemnify AIA Persons for all losses and damages that AIA Persons may suffer in the event that I/we are in breach of any representation and warranty provided by me/us herein. In this Clause, "**Purpose**" means any of the purposes described in the AIA Personal Data Policy, including but not limited to processing of this form, to provide subsequent advice or services to me/us or the insured person in relation to any existing or future policy/policies/programmes that I/we may hold/participate with AIA Singapore.

4. This authorisation and declaration shall bind my/our successors and assignees, and remains valid, notwithstanding death or incapacity. A photocopy of this authorisation shall be effective and valid as the original.

Date (dd/mm/yy)	Signature of Policyowner	Signature of Insured/Covered Member
	Name:	(Not required if Insured/Covered Member is a minor)
	NRIC:	Name:
		NRIC:

Note: No fees, commissions or charges of whatever nature are payable to FSCs or employees of AIA Singapore in respect of this claim.



L2CSENT

Patient's Name :
 Patient's NRIC/Passport No./FIN No.:
 Policy Number :



PART II MEDICAL REPORT FORM (To be completed by Attending Doctor at Insured's expense)

A) Patient's Particulars (From Hospital/Clinic's Record)				
Patient's Name:		NRIC/Passport No./FIN No.:		
B) Details Of Treatment And/Or Surgery (Please complete this part in full for all claims)				
1. Was the patient hospitalised?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details.			
1a. Name of hospital patient was admitted to				
1b. Hospitalisation Period	Date of admission (dd/mm/yy)		Date of discharge (dd/mm/yy)	
1c. Name of attending doctor(s)				
2. Was the treatment or condition due to or related to any of the conditions listed?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please tick the relevant box(es) :			
	<input type="checkbox"/> Sleep Disturbance Disorder <input type="checkbox"/> Physical defects from childbirth <input type="checkbox"/> Elective cosmetic / plastic surgery <input type="checkbox"/> Mental / Nervous Disorder <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Correction for refractive errors of <input type="checkbox"/> Birth control / Sterilization	<input type="checkbox"/> Congenital Anomaly <input type="checkbox"/> Infertility / Sub-fertility <input type="checkbox"/> Impotence test / treatment <input type="checkbox"/> HIV/AIDS related <input type="checkbox"/> Self-destruction /intentional eye self-inflicted injuries <input type="checkbox"/> Drug Abuse / Drug Addiction	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Childbirth <input type="checkbox"/> Miscarriage <input type="checkbox"/> Abortion <input type="checkbox"/> Dental <input type="checkbox"/> Alcoholism	
3. Please provide details on the type of treatment and/or surgery performed.	Type of Treatment/Surgery	Surgical Code	Name of Doctor(s)	Date of treatment (dd/mm/yy)
4. Was the patient treated by any other doctor(s) for the same condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details.			
	Name & Address of Doctor(s)			Date of consultation (dd/mm/yy)



L4MEDRT

AIA Singapore Private Limited (REG.No.201106386R)
 3 Tampines Grande #09-01, Singapore 528799

Patient's Name :
 Patient's NRIC/Passport No./FIN No.:
 Policy Number :



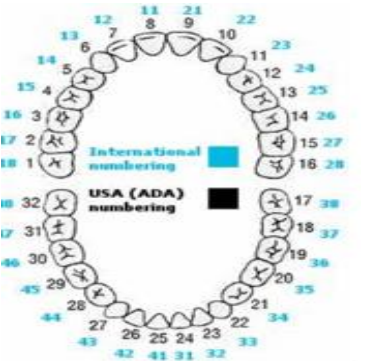
5. Was the patient previously treated for any other serious condition(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details.		
	Diagnosis/Illness	Name & Address of Doctor(s)	Date of diagnosis (dd/mm/yy)
6. Was any diagnostic test(s) and/or scan(s) performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details below and submit a copy of the report(s).		
	Diagnostic Test(s)	Result(s)	Date (dd/mm/yy)
7. Were there any complications that resulted in the healing being prolonged?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details below.		
8. Is there any possibility of a relapse?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details below.		
9. Was the patient referred to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details below and furnish a copy of the referral letter.		
	Name of Doctor(s)	Name & Address of Clinic/Hospital	
10. Was the patient referred to a physiotherapist for further management?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details below.		
	Name of Physiotherapist	Name & Address of Clinic/Hospital	
11. Are you the patient's regular doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please provide details below.		
	Name of Regular Doctor(s)	Name & Address of Clinic/Hospital	

NOTE: Please complete Section (C) if treatment related to an accident OR Section (D) if treatment is related an illness.

Patient's Name :
 Patient's NRIC/Passport No./FIN No.:
 Policy Number :



C) Details Of Accident

1. Date of accident.	Date : ____/____/____ (dd/mm/yy) Time: _____ am / pm		
2. Date of first consultation for this injury	Date : ____/____/____ (dd/mm/yy)		
3. Please describe how the accident occurred.			
4. Please describe the injuries sustained and the anatomical site involved.			
5. Please state the exact diagnosis and the date of the diagnosis of the condition.	Diagnosis	ICD 10 AM Code	Date of Diagnosis (dd/mm/yy)
6. Was the injury sustained consistent with the accident described above?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "No", please elaborate.</i>		
7. Please state the cause of the injury.			
8 If the treatment received was as a result of a dental injury, please provide details of the injured tooth 	8a. Which tooth has been injured? _____		
	8b. Was there any existing conditions of the injured tooth prior to the accident (eg, decay, periodontal disease, and existing crown/bridge)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was it in good repair, at the time of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	8c. Please provide name and address of doctor for the treatment of injured tooth		
9. Was the patient under the influence of alcohol or drugs at the time of the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", please provide details below.</i>		
	Type of Alcohol / Drug Consumed	Blood Alcohol Level / Quantity Consumed	

Patient's Name :
 Patient's NRIC/Passport No./FIN No.:
 Policy Number :



10. Was the patient suffering from any illness/infirmity which would likely have contributed to the injury or prolonged the period of disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please answer 10a - 10c.		
	10a. Please provide details below.		
	Diagnosis	Date of diagnosis dd/mm/yy	Name & address of doctor(s) consulted
	10b. How has the illness/infirmity contributed to the injuries or prolonged the period of disability?		
	10c. What would be the usual recovery time if not for the illness/infirmity?		
11. What is the period of medical leave issued? Temporary Total Disability – The patient <u>cannot engage in each and every duties</u> of his/her usual occupation, business or activities. Temporary partial Disability – The patient <u>can engage in one or more duties</u> of his/her usual occupation, business or activities.	Start Date ____ / ____ / ____ (dd/mm/yy)	End Date ____ / ____ / ____ (dd/mm/yy)	
	Start Date ____ / ____ / ____ (dd/mm/yy)	End Date ____ / ____ / ____ (dd/mm/yy)	
11a. Were medical certificates issued for the above stated period?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please elaborate		
12. Has the patient fully recovered from the injuries?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please elaborate.		
13. Did the patient's injuries result in permanent and total loss of use of the organ or limb involved?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please state the extent of the loss of use of the limb/organ.		
14. Would the injuries sustained have prevented the patient from working in his/ her occupation?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please explain how her/his injuries could have prevented her/him from performing all duties of his/her occupation as stated above?		

Patient's Name :
 Patient's NRIC/Passport No./FIN No.:
 Policy Number :



D) Details Of Illness

1. When did the patient first consult you for the condition?	Date : _____ / _____ / _____ (dd/mm/yy)		
2. What were the sign(s) and symptom(s) presented during the first consultation?			
3. When did the patient first notice the symptoms of the condition diagnosed?	Date : _____ / _____ / _____ (dd/mm/yy)		
4. In your opinion, how long have the symptoms lasted prior to the first consultation with you?			
5. Please state the exact diagnosis and the date of the diagnosis of the condition.	Diagnosis	ICD 10 AM Code	Date of Diagnosis (dd/mm/yy)
6. Was the patient informed of the diagnosis?	<input type="checkbox"/> Yes If "Yes", when was the patient informed? _____ (dd/mm/yy) <input type="checkbox"/> No		
7. What was your advice to the patient?			
8. What is the underlying cause of the condition diagnosed?	Underlying Condition (s)		Date of diagnosis of the underlying condition dd/mm/yy
9. Was the medical condition(s) mentioned in Q(5) require urgent remedial treatment to avoid death or serious impairment to the Insured's immediate or long term health?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please elaborate.		
10. Was the patient aware of the condition diagnosed prior to seeing you?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please elaborate.		
11. Has the patient consulted any other doctors/hospitals for the symptoms/ condition prior to the first consultation with you?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details.		
	Name of Doctor(s)	Name & Address of the Clinic(s)/Hospital(s)	Date of Consultation dd/mm/yy

Patient's Name :
 Patient's NRIC/Passport No./FIN No.:
 Policy Number :



12. Has the patient fully recovered from the illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "No", please elaborate.</i>		
13. Are there <u>any other</u> illness(es) that would have contributed to the patient's condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", please answer 13a - 13c below.</i>		
	13a. Please provide details.		
	Diagnosis	Date of diagnosis dd/mm/yy	Name & Address of doctor(s) who made the diagnosis
	13b. Was the patient informed of the above diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No		
13c. When was the patient informed of the diagnosis? Date : ____/____/____ (dd/mm/yy)			

NOTE: Please complete Section (E) for Organ Transplant Surgery by organ recipient's doctor and organ donor's doctor

E) Details Of Organ Transplantation		
Detail of organ recipient		
1. Please provide us the name and NRIC number of the organ recipient.		
2. Which organ is involved in the Organ Transplantation?	<input type="checkbox"/> Liver <input type="checkbox"/> Kidney <input type="checkbox"/> Other	
3. What is the diagnosis of the organ failure that required transplantation?	Diagnosis of organ failure	ICD 10 AM Code
4. Date diagnosis of organ failure first established (dd/mm/yy)?		
5. When the organ recipient first consulted for the organ failure mentioned above?		
6. Name and address of doctor(s) who referred organ recipient to you.	Name of doctor:	

Patient's Name :
 Patient's NRIC/Passport No./FIN No.:
 Policy Number :



	Address:			
7. Details of surgery of organ transplantation applied for organ recipient (if the recipient is not insured)	Type of Treatment/Surgery	Surgical Code	Name of Doctor(s)	Date of treatment dd/mm/yy
Detail of organ donor				
1. Please provide us the name and NRIC number of the organ donor.				
2. What is the diagnosis established during admission?				
3. What is status of organ donor at moment of harvest organ? <input type="checkbox"/> Living <input type="checkbox"/> Deceased				
4. Type of surgery applied for living organ donor.	Type of Treatment/Surgery	Surgical Code	Name of Doctor(s)	Date of treatment dd/mm/yy

IMPORTANT: Kindly enclose copies of surgical reports, laboratory evidence, diagnostic test results and any other relevant hospital reports that are available.

E) Attending Doctor's Name & Signature

<p>Name of Doctor : _____</p> <p>MCR No : _____</p> <p>Signature : _____</p> <p>Date (dd/mm/yy) : _____</p>	<p>Address/Official Stamp:</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
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