AVIVA LTD
Group Life & Health Claims
4 Shenton Way, #25-01 SGX Centre 2, Singapore 068807
Tel : 6827 7988 Fax : 6827 7705
Company Registration No. 196900499K

HOW TO FILE A GROUP MEDICAL INSURANCE CLAIM

For Outpatient Claims, please assist to submit the following : -

a) Duly completed Claim Form (Section 1)
b) All original final hospital tax invoices, doctor's bill and receipts
c) Referral Letter from General Practitioner (GP) to Specialist / Hospital
d) Any referral form for Laboratory / Blood Test
e) Copy of appointment card to Specialist / Hospital

For Inpatient Claims, please assist to submit the following : -

a) Duly completed Claim Form (Section 1)
b) All original final hospital, doctor's bill and receipts. For admission / surgery at Private Hospital / clinics, please provide Original Final Summary Hospital Bill and Original Final Itemised Hospital Bill.
c) Refer to the guidelines ** below on the requirement for completion of Section 2 of the Claim Form
d) Other additional supporting documents (if any) on the medical condition that can assist in the assessment of the claims:
   – Inpatient Discharge Summary
   – Ambulatory Form / Pre Admission Form
   – Referral Letter from General Practitioner (GP) to Specialist / Hospital
   – Any referral form for Laboratory / Blood Test
e) For follow up visits following your hospitalisation / surgery claim, simply let us have your original bills & receipts. Group Medical Insurance Claim Form is not required.

Note : The Insured Member is required to furnish us the above documents within one month of discharge from the hospital.

** GUIDELINES FOR THE REQUIREMENT OF MEDICAL REPORT

The following procedure applies to claimants who are admitted into various hospitals:

Hospitalisation at	Medical Report to be applied by :	Procedures	Cost of Medical Report to be borne by Aviva Ltd :
Private Hospitals	Claimant	To submit Section 2 of the Claim Form duly completed by the Attending Physician / Surgeon to Aviva Ltd	Nil
*AH, *CDC, *CGH, *KKH, *KTP, *NCC, *NHC, *NSC, *NUH, *SGH, *SNEC, *TTSH, & other Singapore Govt./Restructured Hospitals	Aviva Ltd	Aviva Ltd will apply for the report, where necessary. The report fee in excess of S$75 will be recovered from the client once the claim has been processed.	S$75/-

*AH – Alexandra Hospital
*CDC – Communicable Disease Centre
*CGH – Changi General Hospital
*KKH – KK Women's and Children's Hospital
*KTP – Khoo Teck Puat Hospital
*NCC – National Cancer Centre
*NHC – National Heart Centre
*NSC – National Skin Centre
*NUH – National University Hospital
*SGH – Singapore General Hospital
*SNEC – Singapore National Eye Centre
*TTSH – Tan Tock Seng Hospital

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GROUP MEDICAL INSURANCE CLAIM FORM

SECTION 1 : TO BE COMPLETED BY POLICYHOLDER & INSURED PERSON

Help us To Serve YOU Better – Contact & Payment Details				
Policy No:	Name of Company:			
Best Way to Contact You Please Tick (at least one or both)	☐ Mobile Mobile No:	☐ Email Email:	Address Of Employee:	
Your Bank Details for Direct Credit	Bank Name:	Bank Code: / Branch Code:	Bank A/C No:	
* Note: Payment will not be made to employee unless prior arrangement was made by your employer with Aviva Ltd.				
Type of Claim – Please Tick (One Claim Per Member)	☐ Inpatient	☐ Outpatient		

About YOU – To Be Completed by Employee				
Name:		NRIC:	Employee ID:	
Gender: ☐ M / ☐ F	Date of Birth:	Date of Employment:	Occupation:	Nationality:

About YOUR Dependant – Applicable For Dependant Claim ONLY			
Name:		NRIC:	Date of Birth:
Gender: ☐ M / ☐ F	Nationality:	Relationship to Employee: ☐ Child / ☐ Spouse	Occupation:

☐ Illness	☐ Accident
Nature of Illness:	Accident Date & Time: Brief Description of Accident:
Nature of Operation (**APPLICABLE if there is surgery performed**):	
Date of FIRST Treatment:	
Name of Referring Doctor (**NOT APPLICABLE for GP Visit**):	
Were you / your dependant hospitalised as a result of an illness or accident? ☐ Yes ☐ No If yes, please provide the Date of Admission & Date of Discharge below	
Date of Admission:	Date of Discharge:

CONSENT & AUTHORISATION

I/We hereby authorise Aviva Ltd to request from any hospital, physician, person or organisation, all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records concerning the patient at any time and authorise the prior mentioned organisations to disclose all such information to Aviva Ltd. A photocopy of this authorisation shall be considered as effective and valid as the original.

I/We declare that the statements and answers stated are true and complete to the best of my/our knowledge and belief.

I/We consent to Aviva (and Aviva related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s), my/our insurance coverage and/or managing my/our relationship with Aviva.

I/We also consent to Aviva (and Aviva related group of companies) transferring my/our personal data to Aviva related group of companies and/or third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

For full details of the purposes of collection, use and disclosure of your personal data, please visit http://www.aviva.com.sg/pdpa.html.

Signature of Employee:	Signature of Patient (For Dependant):	Date:

For Your EMPLOYER (NOT APPLICABLE FOR NAMED BASIS COVER)		
Effective Date of Coverage:	Date of Employment:	Plan:
Company Name & Stamp:	Signature of Employer:	Date:

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SECTION 2 : MEDICAL REPORT (TO BE COMPLETED BY ATTENDING PHYSICIAN / SURGEON)

For admission to Private Hospital or Hospital outside Singapore, claimant must arrange to have this section completed by the Attending Physician when submitting a claim.

Patient Information

Policy No:	Name of Company:	
Name of Patient:	NRIC/Passport No:	Admission Period:

Nature of Illness

01) Final Diagnosis (Based on ICD 10) of illness or extent of Injury

DRG Code ☐☐☐☐ ICD Code ☐☐☐☐ ICD Code ☐☐☐☐

Date of Diagnosis: _____

02) Given the aetiology of the condition, please state the estimated date of such condition would be in existence.

03) What is the cause of illness / injury?

04) What is the anatomy of this illness?

Nature of Treatment / Surgery

05) Date of surgical procedures or treatment rendered : _____

Operation Code ☐☐☐☐ Operation Table ☐☐

06) Describe the surgical procedures or treatment rendered. If no surgery was performed, please state treatment / medication given

07) If excision was performed, please indicate the size of the lesion / tumor. (Please attach a copy of the Histology Report)

08) Name of
- a) Physician _____
- b) Surgeon _____
- c) Anesthetist _____

09) Is the condition/treatment related to:

		Yes	If 'Yes", please elaborate.	No
a)	Pregnancy or childbirth	☐	_____	☐
b)	Abortion or Miscarriage	☐	_____	☐
c)	Infertility or Sub-fertility Condition	☐	_____	☐
d)	Congenital Anomaly	☐	_____	☐
e)	Genetic or Chromosomal Disorder	☐	_____	☐
f)	Mental or Psychiatric Condition	☐	_____	☐
g)	Cosmetic Surgery	☐	_____	☐
h)	Is the surgery for correction of short sightedness?	☐	_____	☐
i)	Is the surgery for dental purposes?	☐	_____	☐

Medical History

10) Please provide the name and address of referring doctor if patient was referred to you.

11) When did the patient first consult you for this condition?

12) Nature and Date of Treatment rendered

13) What were the symptoms/complaints prior to consulting you?

14) Please indicate the nature of Symptoms and date Symptoms first started

15) If there is no symptom presented, what has prompted the patient to see you?

16) Please specify the approximate date of discovery of the illness or injury

17) How long has the illness / injury existed prior to consulting you?

18) Has the patient ever had the same or similar condition / symptom?

☐ Yes ☐ No ☐ Not to my knowledge

19) Doctors previously consulted by the patient for the above condition.
- Name of Doctor: _____
- First Consultation: _____
- Name of Clinic: _____
- Address: _____

Follow-up Treatment

20) Is the patient still under your care for this condition? ☐ Yes ☐ No
If yes, please state the estimated duration that patient needs to follow-up with you.

If "No", please give date service was terminated and furnish name and address of doctor if the patient has been referred to another doctor for follow-up

_____
Signature of Physician / Surgeon

_____
Date

_____
Name / Designation

_____
Name and Address of Clinic / Hospital & Stamp