AXA Life Insurance Singapore Pte Ltd
AXA Health Customer Care Centre
123 Penang Road
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Reimbursement Claim Form (In-Patient)

This claim form is not an admission of liability.
Please use a separate claim form for each separate admission.

GlobalCare Health Plan

Date received:

Received by:

Please complete this form in full in order to assure a fast and accurate processing.
All fields are compulsory. Thank you for your cooperation.

A. ADMINISTRATIVE (Section A to be completed by policy holder)		
Policyholder:		Policy number:
Email address :		Contact number:
PATIENT'S DETAILS		
Patient name:		Date of birth:
ID / Passport number:	Gender: (M / F)	Plan:
Email address:		Contact number:

Was there any previous consultation / treatment / hospitalisation in the last 5 years for this condition, in this hospital or any other facilities?

If YES, please provide details below:

Date	Disease / Disorder (details of treatment)	Doctor / Hospital	Contact details

B. MEDICAL SECTION (Section B to be completed by medical practitioner)		
Symptoms presented:	Date the patient first became aware of any signs or symptoms for this condition: dd / mm/ yyyy	Date on which the patient first presented to any doctor for this condition: dd / mm/ yyyy
Medical condition / diagnosis:		
Investigation (describe necessary investigations requested / required to define the diagnosis):		
If claim is related to pregnancy, is pregnancy conceived from natural conception? Yes ☐ No ☐		
Date of admission & discharge: dd / mm / yyyy to dd / mm / yyyy		

TREATMENT ADVISED			
Medicines:	Dose:	Frequency:	Duration:
Procedure (please give details of medical procedure if any):			

FURTHER TREATMENT PLAN
Please give details of any further treatment plan:

MEDICAL PRACTITIONER'S DECLARATION

I declare that I am the patient's medical practitioner, and that the particulars given are true and correct to the best of my knowledge

Name : ……Signature ……Contact number : ……

Hospital/Clinic Stamp Date ……

C. OTHER INSURER'S DETAILS

Is this treatment related to accident? Yes ☐ No ☐ If you have answered 'YES', please give details of the accident.)	Is this treatment covered under another insurance policy? Yes ☐ No ☐

If you have answered 'YES' to either of these questions, please give the name of the related insurance company involved.
(Kindly submit a copy of the other insurance company's claim settlement letter / payment voucher):

D. DECLARATION & AUTHORISATION

I hereby confirm:

1. that I authorise the Physician, Hospital / Clinic or any other medical institution to give the information and / or medical record, according to the diagnosis and / or medication treatment which given to me or my family which being as the Insured, and
2. that I authorise AXA Life Insurance Singapore Pte Ltd and its designated third party administrators; to gather further information / medical records from the Hospital and or other parties related to the diagnosis and or health services provided to me or eligible members of my family which may be required to process the claim in accordance with existing policy and term conditions.
3. that all information on this Reimbursement Claim Form (In-patient) was written truthfully and I hereby agree that this Letter of Authority to be used promptly.
4. that copy of this Declaration is as valid and has power in accordance with the original document.
5. I authorise / do not authorise my Financial Advisor / Agent to discuss medical conditions as necessary with my insurer or its authorised agent on my behalf.

Policyholder signature: Date:

Name of Insured/Policy holder :	ID/PP No. of Insured/Policy holder :	Relationship :
Signature of Insured/Policy holder :	Mailing address :	Contact number :
Name of financial consultant/agent:	Contact number:	

E. THE FOLLOWING DOCUMENTS MUST ACCOMPANY THE CLAIM DURING SUBMISSION:

- ☐ Claim form which is to be completed fully (original)
- ☐ Original payment receipt (original / certified copy)
- ☐ Results of the diagnostic test/s (Laboratory result, X-Ray, etc – original / certified copy)
- ☐ Prescription (original / certified copy)
- ☐ Hospital Discharge Note (if applicable)

F. REIMBURSEMENT OF CLAIMS

Amount claimed:

Payment will be made in the currency defined in the plan unless we agreed otherwise in writing and bank charges incurred will be borne by the policy holder.

Telegraphic bank transfer. The account holder must be the policy holder

Bank account number: …… Bank SWIFT code: ……..

Name of bank:…… Bank address: ……

*If you have any questions regarding this form or any other aspects of the coverage, please contact our **AXA Health Customer Care Centre** at **65-6308 9525** quoting your policy / membership numbers. Claims must be submitted along with all supporting documents within **90** days from date of service. Send this claim form together with all supporting documents to **AXA Health Customer Care Centre** at **123 Penang Road, #06-13 Regency House, Singapore 238465**.*