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Group Hospital & Surgical Claim Form

Instructions:

Please furnish the following documents within one month from date of discharge from hospital:

For hospitalisation in Government / Restructured Hospital:

(1) Duly completed and signed claim form (Part 1)

(2) All original final hospital bills, doctor's bills and receipts

(3) Inpatient Discharge Summary / Day Surgery Admission Form / Ambulatory Form / Pre- Admission Form

(4) Claim Settlement Advice from Medisave-approved Integrated Shield Plan (if any) –example, AIA Healthshield, NTUC Incomeshield, AVIVA Myshield, Prudential Prushield or Great Eastern Supremehealth

For hospitalisation in Private Hospitals / Clinics / Hospitals outside Singapore

(1) Duly completed and signed claim form (Part 1)

(2) All Original Final Summary and Itemised Hospital Bills, Doctor's bills and receipts

(3) Claim Settlement Advice from Medisave-approved Integrated Shield Plan (if any) –example, AIA Healthshield, NTUC Incomeshield, AVIVA Myshield, Prudential Prushield or Great Eastern Supremehealth

GUIDELINES FOR REQUIREMENT OF MEDICAL REPORT

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

Hospitalization at	Medical Report to be applied by :	Procedures	Cost of Medical Report to be borne by AXA:
Private Hospitals	Claimant	To submit Part 2 of the Claim Form duly completed by the Attending Physician / Surgeon to AXA.	Nil
*AH, *CDC, *CGH, *KKH, *KTP, *NCC, *NHC, *NSC, *NUH, *SGH, *SNEC, *TTSH, & other Singapore Govt./ Restructured Hospitals	AXA	AXA 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	* NHC	-	National Heart Centre
* CDC	-	Communicable Disease Centre	* NSC	-	National Skin Centre
* CGH	-	Changi General Hospital	* NUH	-	National University Hospital
* KKH	-	KK Women's and Children's Hospital	* SGH	-	Singapore General Hospital
* KTP	-	Khoo Teck Puat Hospital	* SNEC	-	Singapore National Eye Centre
* NCC	-	National Cancer Centre	* TTSH	-	Tan Tock Seng Hospital

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GROUP HOSPITAL & SURGICAL CLAIM FORM

PART 1 : TO BE COMPLETED BY POLICYHOLDER & INSURED MEMBER

A. EMPLOYEE & / OR DEPENDANT				
Policyholder (Employer)			Policy Number	
Insured Member (Employee)			NRIC / Passport	Date of Birth
Occupation		Date of Employment	Plan No.	Sex F ☐ M ☐
Email Address		Contact Number Office: HP:		
Claimant (Dependant)	Relationship Spouse ☐ Child ☐	NRIC No / Passport	Date of Birth	Sex F ☐ M ☐
Is the dependant employed? Yes ☐ No ☐ If yes, please furnish the name of employer:		Name and address of regular / family doctor		

B. DETAILS OF ILLNESS / ACCIDENT			
1) Nature of Illness / Final Diagnosis		Symptoms experienced	
Date symptoms first started		Date First Treated	
2) Accident : Date & Time		Describe How Accident Happened & Nature of Injury	
Date of Admission	Date of Discharge	Name of Hospital / Clinic	Name and address of attending physician
Was the Accident work-related? Yes ☐ No ☐		Are you entitled to claim against Work Injury Compensation? Yes ☐ No ☐	

C. CLAIMS PAYMENT DETAILS

Claim cheque to be made payable to: (Please tick ☑ one only) Employer ☐ Employee ☐

D. DECLARATION AND AUTHORISATION

(This part must be signed by the patient or patient's parent / legal guardian if the patient is below 21 years of age)

I hereby authorise AXA Life Insurance Singapore Private Limited to request from any physician, hospital, dentist, person or organisation, all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment and copies of all hospital and medical records concerning me at any time and authorise the prior mentioned organisations to disclose all such information to AXA Life Insurance Singapore Private Limited. A photocopy of this authorisation shall be considered as effective and valid as the original.

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

Signature of Employee	Signature of Patient (if patient is dependant)	Date (DD/MM/YY)

E. TO BE COMPLETED BY EMPLOYER

Signature of Employer	Company's Name and Stamp	Date (DD/MM/YY)

AXA Life Insurance Singapore Private Limited (Company Reg. No. 199903512M)
8 Shenton Way #27-02 Singapore 068811
Employee Benefits Team Tel: 6880 2648 Fax: 6880 2656
Website: www.axalife.com.sg

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PART 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.

1) Name of Patient

NRIC / Passport No:

2) Name of Insured Member's company :

3) Final Diagnosis (Based on ICD, 1975 Revision, WHO) of illness* or extent of injury.

ICD Code ☐☐☐☐ ICD Code ☐☐☐☐ ICD Code ☐☐☐☐

4) Date of Diagnosis?

5) What is the cause of illness / injury

6) Is the condition/treatment related to:

		Yes	No
a)	Pregnancy or childbirth	☐	☐
b)	Abortion / Miscarriage / Impotency / Sterilisation	☐	☐
c)	Infertility or Sub-fertility Condition	☐	☐
d)	Congenital Anomaly / Genetic / Chromosomal Disorder	☐	☐
e)	STD / AIDS and Illness or Disease related to HIV	☐	☐
f)	Cosmetic Surgery	☐	☐
g)	Mental / Psychiatric Condition	☐	☐
h)	Self-inflicted injury / Drug Addition / Alcoholism	☐	☐

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

8) How long has the illness / injury been existing prior to consulting you?

9) Did the patient have any symptoms prior to consulting you? ☐ Yes ☐ No
If "Yes", please indicate the nature of Symptoms and date Symptoms first started:

10) When did the patient first consult you for this condition

11) Nature and Date of Treatment rendered.

12) Has the patient ever had the same or similar condition / symptom? ☐ Yes ☐ No ☐ Not to my knowledge
If "Yes", please indicate when and describe

13) Doctors previously consulted by the patient for the above condition.

Name of Doctor	First Consultation Date	Name of Clinic	Address

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

15) Period of Hospitalisation

16) Surigical Procedure Performed (if applicable)

Admission Date	Discharge Date	Surgical Procedure	Operation Code	Operation Table
			☐☐☐☐☐☐	☐☐
Admission Date	Discharge Date	Surgical Procedure	Operation Code	Operation Table
			☐☐☐☐☐☐	☐☐

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

18) Name of
a) Physician _____
b) Surgeon _____
c) Anaesthetist _____

19) Is the surgery done for cosmetic reason? ☐ Yes ☐ No
Is the surgery for correction of short sightedness? ☐ Yes ☐ No
Is the surgery for dental purposes? ☐ Yes ☐ No
If "No", please explain why surgery is necessary.

20) Is the patient still under your care for this condition? ☐ Yes ☐ No
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