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Employee Benefits Group Medical Insurance Claim Form

Special Instruction: Dependents above 19 years of age, are required to attach a copy of his/her student pass for every claim submission.

For Outpatient Claims (General Practitioner (GP), Specialist (SP), Diagnostic X-rays & Lab Test (XRLB), Dental), please submit the following documents within one month from the date of consultation or treatment:

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

(2) All original tax invoices, doctors' bills and receipts (For Dental Claim-To submit Part 3 of claim form completed by dentist if Invoice does not reflect breakdown)

(3) Copy of Referral Letter from GP to Specialist / Hospital **OR** Copy of appointment card from Specialist / Hospital

(4) Copy of any referral form for laboratory / blood test / x-rays

(5) Copy of CPF Medisave Transactions Statement with **HRN No (Hospital Reference No)** if you have utilized your Medisave to make payment. It can be obtain from www.cpf.gov.sg, go to "My Statement" and click on "Section B – Medisave and/or MediShield Life to view payment details

For Inpatient Claims, please submit the following documents within one month from date of discharge from hospital:

Admission to Government / Restructured Hospital:

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

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

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

(4) Copy of CPF Medisave Transactions Statement with **HRN No (Hospital Reference Number)** if you have utilized your Medisave to make payment. It can be obtain from www.cpf.gov.sg, go to "My Statement" and click on "Section B – Medisave and/or MediShield Life to view payment details

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

Admission to Private Hospitals / Clinics / Hospitals outside Singapore

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

(2) Medical Report (Part 2 of the claim form)

(3) All Original Final Summary and Itemised Hospital Bills, Doctors' bills and receipts

(4) Copy of CPF Medisave Transactions Statement with **HRN No (Hospital Reference Number)** if you have utilized your Medisave to make payment. It can be obtain from www.cpf.gov.sg, go to "My Statement" and click on "Section B – Medisave and/or MediShield Life to view payment details

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

MEDICAL REPORT REQUIREMENT

Please note that the requirements for medical report submissions differ for admissions into Private and Singapore Government /Restructured 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
Singapore Govt./ Restructured Hospitals - Refer to the hospital list below	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
* 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
* NTFG - Ng Teng Fong General Hospital
* 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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FOR EMPLOYEE BENEFITS CLAIMS DEPT USE ONLY:

								-		
								-		

Employee Benefits Group Medical Insurance Claim Form

PART 1: TO BE COMPLETED BY POLICYHOLDER & INSURED MEMBER - Please tick ☑ the type of claim and use 1 claim form per member

☐ Outpatient GP ☐ Outpatient SP / XRLB ☐ Dental ☐ Pre-Hospitalisation ☐ Hospitalisation ☐ Post-Hospitalisation

Policyholder (Company):

Policy Number:
(8 digit number beginning with "6" or "8")

A. EMPLOYEE & / OR DEPENDANT

Insured member (Employee) – Name as per NRIC / Passport / FIN No.	NRIC / Passport / FIN No.	Date of birth (DD/MM/YYYY)	Gender ☐ Male ☐ Female
Contact number Mobile: Office:	Occupation	Date of employment (DD/MM/YYYY)	Plan No
Email Address:			
Claimant (Child/Spouse) – Name as per NRIC / Passport / FIN No.	NRIC / Passport / FIN No.	Date of birth (DD/MM/YYYY)	Gender ☐ Male ☐ Female
Relationship to Employee ☐ Child ☐ Spouse	Is the dependent employed? ☐ Yes ☐ No If yes, please furnish the name of employer:	Name and address of regular / family doctor of claimant	

B. DETAILS OF ILLNESS / ACCIDENT

1) Nature of illness / Final diagnosis (e.g: cough, flu, fever)	Symptoms experienced
Date symptoms first started	Date first treated
2) Accident: Date: Time:	Describe how the accident happened & details of injuries/nature of Injury (e.g: fracture, cut, etc.)

APPLICABLE FOR HOSPITALISATION ONLY		Name of hospital / clinic	Name and address of attending physician
Date of admission	Date of discharge		
Are you entitled to claim against Work Injury Compensation? ☐ Yes ☐ No			Was the accident work-related? ☐ Yes ☐ No

C. CLAIMS PAYMENT DETAILS – Please note that mode of payment will be as per agreed by Policyholder with AXA Insurance Pte Ltd

Cheque Payment: (Please tick ☑ one only) ☐ Employer ☐ Employee Has there been a change in bank account details since your last claim submission ☐ Yes ☐ No

GIRO Payment: **Bank Name** **Branch Code (3 digits)** **Bank A/C No:**

D. DECLARATION AND AUTHORISATION (This part must be signed by patient or patient's parent / legal guardian if patient is below 21 years of age)

I/We confirm that I am/We are the claimant and/or the Policyholder and I/We declare that all the particulars given above are to the best of my/our knowledge.

I / We hereby authorise AXA Insurance Pte Ltd ("AXA") to request from any physician, hospital, dentist, person or organization (including the Policyholder (the "Employer"), all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment and copies of all hospital and medical records concerning me / us and/or my dependants (where applicable) at any time and authorise the prior mentioned organizations to disclose all such information to AXA. A photocopy of this authorisation shall be considered as effective and valid as the original.

In connection with my / our claim, I / we give consent for AXA Insurance (collectively "AXA") 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/us and/or my dependents, 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 Policyholder when claiming under a Group Policy) for the purpose of enabling AXA to provide me/us and/or my dependents (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/ or managing my / our claims or the Employer's Group Policy(ies) with AXA (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")."

Signature of Employee | Signature of Patient (for dependents above age 21) | Date (DD/MM/YY)

E. TO BE COMPLETED BY POLICYHOLDER

Signature of Authorized Officer & Designation | Company's stamp | Date (DD/MM/YY)

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PART 2: MEDICAL REPORT - TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SURGEON
For Admission to Private Hospital or Hospital outside Singapore, claimant must arrange to have this section completed by the Attending Physician before submitting a claim.

1) Name of Patient:

NRIC / Passport / FIN No:

2) Insured Member(Employee)'s Name:

Company Name:

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?

5) Is the condition / treatment related to:

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

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

8) How long has the illness / injury existed prior to consultation with you?

9) Did the patient have any symptoms prior to consultation with 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? If "Yes", please indicate when and describe
☐ Yes ☐ No ☐ Not to my knowledge

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

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

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 was 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
Name:
Designation:
Date:

Name and Address of Clinic / Hospital & Stamp

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PART 3: DENTAL - TO BE COMPLETED BY DENTIST
For visits to a dentist, claimant must arrange to have this section completed by the Attending Dentist before submitting a claim.

1) Name of Patient: NRIC / Passport / FIN No:	2) Insured Member(Employee)'s Name: Company :

CLAIMS DETAILS

3) Date of consultation

4) Complaints and/or symptoms:

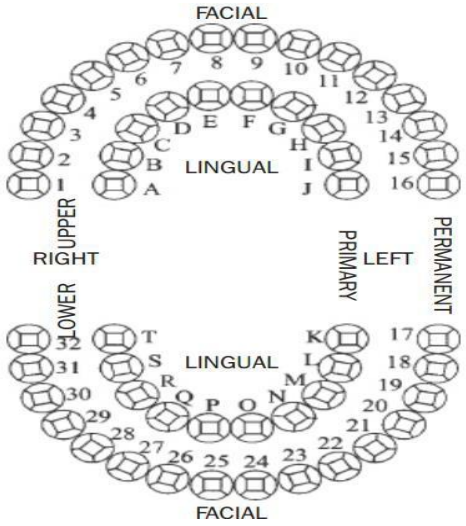
5) Nature of Treatment. Please Tick (❑) where appropriate:

☐ Routine dentistry ☐ Accident

If treatment is required as the result of an accident, please provide the following details:

6) Date / Time of Accident	7) Describe How Accident Happened & Nature of Injury

8) Specify the recommended investigations, and/or procedures using the tooth number as shown on the teeth map on the right.



	Type of Dental Services Rendered		Charges	FOR AXA INSURANCE'S USE ONLY	
				Benefit Limits	Amount Payable
a)	Consultation / Examination		S$		S$
b)	X-rays		S$		S$
c)	Scaling & Polishing		S$		S$
d)	Filling		S$		S$
e)	Extraction	- Routine / complicated extraction	S$		S$
		- Surgical extraction of wisdom tooth	S$		S$
f)	Medication		S$		S$
g)	Pulp/Root Canal Treatment		S$		S$
h)	Periodontal Treatment		S$		S$
i)	Crowning		S$		S$
g)	Others (Please Specify)		S$		S$
	TOTAL		S$		S$

Signature of Dentist
Name:
Date:

Name and Address of Clinic / Hospital & Stamp