

**AVIVA LTD**

Customer Service, Individual Health Claims (Fax: 6827 7705)
 Customer Service, Individual Life Claims (Fax: 6827 7900)
 4 Shenton Way, #01-01 SGX Centre 2, Singapore 068807
 Tel: 6827 7988
 Company Registration No.196900499K

MEDICAL INSURANCE CLAIM FORM (RETAIL / INDIVIDUAL)

The Insured Member is required to furnish the following documents to his/her Insurance Representative or Aviva Ltd when making a claim:

- (1) Complete the following Claim Form. (3) Your doctor must complete and sign Section D of this Claim Form.
 (2) Attach **originals** of all relevant documents and final detailed hospital / doctor's bills and receipts and Inpatient Discharge Summary (If applicable). (4) Use a new Claim Form for each separate claim or illness.

Please tick (✓) the appropriate box:

RETAIL (GLOBALHEALTH, IDEALMEDICAL, MYGLOBALBENEFITS):

- Inpatient Claim Outpatient Claim

INDIVIDUAL:

- Medical Claim

SECTION A: TO BE COMPLETED BY POLICYHOLDER

POLICY NUMBER(S): _____

1) Name of Policyholder	IC / Passport No.	Occupation	Marital Status	Date of Birth	Sex
2) Name of Patient (If other than Policyholder)	IC / Passport No.	Occupation	Marital Status	Date of Birth	Sex
3) Present Home Address			4) Contact No. (O) : (HP) :	5) Email Address	

Details of Illness / Injury :

- 6) Is the treatment recommended or referred by physician or surgeon? YES NO If "Yes", please state:-
 a) Name of Referring Physician/Surgeon b) Address of Referring Physician/Surgeon

- 7) Sickness b) Describe Nature of Sickness and Operation
 a) Date First Began

- 8) Accident b) Time c) Describe How and When Accident Happened
 a) Date of Accident

- 9) Treatment b) Name and Address of the doctor whom the patient first consulted for the sickness or injury?
 a) Date First Treated c) Name and Address of the doctors, or specialists who attended to the patient during his/her hospital's confinement

- 10 a) Date of Admission b) Date of Discharge c) Date of Operation, if any

- 11) Is the Patient presently also insured for medical under another insurance company? YES NO
 If "Yes", please state (a) Name of Insurance Company: b) Policy No.:

SECTION B: TO BE COMPLETED FOR CLAIM UNDER GLOBAL HEALTH, IDEALMEDICAL OR MYGLOBALBENEFITS ONLY

- 12) Please advise us your mode of contact : via Email via Telephone / Handphone

- 13) **SETTLEMENT OPTION:** (Payee refers to the Policyholder or Insured Member only.)

(a) FOR PAYMENT DRAWN IN SINGAPORE ONLY – Please note payment will be credited directly to the Payee's bank account stated below.

Direct Credit: Name of Account Holder: _____ Name of Bank: _____

Name of Bank Branch or Branch Code: _____ Bank Account No.: _____

(b) FOR PAYMENT DRAWN **OUTSIDE** SINGAPORE (Please tick (✓) where is applicable)

() **Demand Draft.** Name of Payee: _____ Currency type: _____

() **Telegraphic Fund Transfer.** Please note that this settlement option is only available if the payment is more than S\$1,000/- (For MyGlobalBenefits, this settlement option is available if the payment is more than S\$200/-). Please provide us with the following bank details:

Name of Account Holder: _____ Name of Beneficiary Bank & Branch: _____

Beneficiary Bank Account No.: _____ Address of Bank & Branch: _____

SWIF Address / Clearing Code (if applicable): _____

Currency Type: _____

NOTES: (i) For payment drawn outside Singapore, if preferred currency type is not specified, claim will be paid in policy currency. (ii) Payment shall not include clinic, physician and any other medical providers. (iii) If CPF Medisave is used, the appropriate amount would be credited into the respective CPF Medisave account.

SECTION C: DECLARATION & 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 _____ (NRIC No. _____) 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 declare that the statements and answers stated are true and complete to the best of my knowledge and belief.

Signature of Policyholder

Signature of Patient

Date (DD / MM / YY)

SECTION D: TO BE COMPLETED BY ATTENDING PHYSICIAN / SURGEON (For Retail Outpatient claims, please complete items 1 to 12 only)
(The Medical Report Fee, if any, will be borne by the Claimant)

1) Name of Patient NRIC / Passport No:	2) Name of Insured Person's company :																								
3) Final Diagnosis (Based on ICD, 1975 Revision, WHO) of illness* or extent of injury. Date of Diagnosis	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">DRG Code</td> <td style="text-align: center;">ICD Code</td> <td style="text-align: center;">ICD Code</td> </tr> <tr> <td style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </td> </tr> </table>	DRG Code	ICD Code	ICD Code	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																		
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4) What is the cause of illness/injury?																									
5) Is the condition/treatment related to: 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	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Yes</td> <td style="text-align: center;">If "Yes", please elaborate.</td> <td style="text-align: center;">No</td> </tr> <tr> <td style="text-align: center;">a) <input type="text"/></td> <td style="text-align: center;">_____</td> <td style="text-align: center;"><input type="text"/></td> </tr> <tr> <td style="text-align: center;">b) <input type="text"/></td> <td style="text-align: center;">_____</td> <td style="text-align: center;"><input type="text"/></td> </tr> <tr> <td style="text-align: center;">c) <input type="text"/></td> <td style="text-align: center;">_____</td> <td style="text-align: center;"><input type="text"/></td> </tr> <tr> <td style="text-align: center;">d) <input type="text"/></td> <td style="text-align: center;">_____</td> <td style="text-align: center;"><input type="text"/></td> </tr> <tr> <td style="text-align: center;">e) <input type="text"/></td> <td style="text-align: center;">_____</td> <td style="text-align: center;"><input type="text"/></td> </tr> <tr> <td style="text-align: center;">f) <input type="text"/></td> <td style="text-align: center;">_____</td> <td style="text-align: center;"><input type="text"/></td> </tr> <tr> <td style="text-align: center;">g) <input type="text"/></td> <td style="text-align: center;">_____</td> <td style="text-align: center;"><input type="text"/></td> </tr> </table>	Yes	If "Yes", please elaborate.	No	a) <input type="text"/>	_____	<input type="text"/>	b) <input type="text"/>	_____	<input type="text"/>	c) <input type="text"/>	_____	<input type="text"/>	d) <input type="text"/>	_____	<input type="text"/>	e) <input type="text"/>	_____	<input type="text"/>	f) <input type="text"/>	_____	<input type="text"/>	g) <input type="text"/>	_____	<input type="text"/>
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g) <input type="text"/>	_____	<input type="text"/>																							
6) Please specify the approximate date of discovery of the illness or injury	7) How long has the illness / injury been existed prior to consulting you?																								
8) Did the patient have any symptoms prior to consulting you? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please indicate the nature of Symptoms and date Symptoms first started:																									
9) When did the patient first consult you for this condition	10) Nature and Date of Treatment rendered.																								
11) Has the patient ever had the same or similar condition / symptom? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not to my knowledge If "Yes", please indicate when and describe																									
12) Doctors previously consulted by the patient for the above condition. <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;"><u>Name of Doctor</u></td> <td style="width:15%;"><u>First Consultation Date</u></td> <td style="width:20%;"><u>Name of Clinic</u></td> <td style="width:32%;"><u>Address</u></td> </tr> </table>		<u>Name of Doctor</u>	<u>First Consultation Date</u>	<u>Name of Clinic</u>	<u>Address</u>																				
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13) Describe the surgical procedures or treatment rendered. If no surgery was performed, please state treatment / medication given	14) Date of surgical procedures or treatment rendered : _____ <table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Operation Code</td> <td style="text-align: center;">Operation Table</td> </tr> <tr> <td style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> </td> </tr> </table>	Operation Code	Operation Table	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>																				
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15) If excision was performed, please indicate the size of the lesion / tumor. (Please attach a copy of the Histology Report)	16) Name of a) Physician _____ b) Surgeon _____ c) Anaesthetist _____																								
17) Is the surgery done for cosmetic reason? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the surgery for correction of short sightness? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the surgery for dental purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "No", please explain why surgery is necessary.																								
18) Is the patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> 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.																								
19) Admission period	20) What is the prognosis of this illness?																								

* Please (✓) the appropriate illness classification

<input type="checkbox"/> Alimentary system, includes liver & biliary tract	<input type="checkbox"/> Diseases of the nervous system	<input type="checkbox"/> Metabolic & Endocrine disease
<input type="checkbox"/> Musculo-skeletal system & connective tissue disorder	<input type="checkbox"/> Cancer / Malignant tumour growth	<input type="checkbox"/> Eye
<input type="checkbox"/> Haematological disorders / autoimmune disorder	<input type="checkbox"/> Respiratory system	<input type="checkbox"/> Female disease / condition
<input type="checkbox"/> Diseases of skin and subcutaneous tissue	<input type="checkbox"/> Cardiovascular system	<input type="checkbox"/> Infectious disease
<input type="checkbox"/> Symptoms, signs and ill-defined conditions	<input type="checkbox"/> Ear, Nose & Throat system	<input type="checkbox"/> Dental / bucco - mucosal
<input type="checkbox"/> Diseases of genito-urinary system	<input type="checkbox"/> Psychological / Psychiatric	

_____ Signature of Physician / Surgeon	_____ Date
_____ Name / Designation	_____ Name and Address of Clinic / Hospital & Stamp