



RETAIL & INDIVIDUAL MEDICAL CLAIM FORM

IMPORTANT: Please furnish the following documents to Aviva Ltd for your medical claim:

1. Completed Claim Form
2. Original Final Bills
3. Copy of the Inpatient Discharge Summary, diagnostic reports, laboratory evidence and any relevant hospital reports that are available.
4. For hospitalization or day surgery claim, Section E of the Claim Form needs to be completed by the attending doctor/surgeon at the expense of the claimant.

Please tick (✓) the appropriate box: MyShield / MyHealthPlus Claim Other Medical Plan **Policy No.** _____

Section A: Details of Assured (Policyholder) & Life Assured		
Name of Assured (Policyholder)		NRIC/FIN/Passport No.
Occupation	Date of Birth	Gender
Name of Life Assured		NRIC/FIN/Passport No.
Occupation	Date of Birth	Gender
Details of Illness / Injury		
1) Date symptoms 1st started	2) Describe the symptoms 1 st presented	
3) Date 1 st consulted doctor for the condition		
4) Name & Address of the doctor 1 st consulted for the condition		
5) Final Diagnosis		6) Date of Diagnosis
7) Date of Admission	8) Date of Discharge	9) Date of Operation, if any
10) Name and address of doctor or specialist who attended to the Life Assured during his/her hospital's confinement		
11) What was the treatment (including any surgery) given to the Life Assured?		
12) Is the Life Assured also insured under an employer's group medical plan or any other medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Name of Insurance Company</u> <u>Employer's Name (if applicable)</u> <u>Policy No. (if any)</u>		
If the Illness/Injury resulted from an Accident, please complete this section.		
1) Place of Accident		2) Date and Time of Accident
3) Describe in detail how the accident happened		4) Nature and extent of injuries
Section B: Policyholder's Bank Account Details - Default payment method is direct credit to the account below		
Name of Bank Account Holder(s)		Type of Account: <input type="checkbox"/> Single <input type="checkbox"/> Joint (Please tick box)
Name of Bank	SWIFT/BIC Code	Bank Account No.
Notes: (i) Please provide a copy of your bank statement/bank book for account verification and a copy of NRIC/Passport of all bank account holders. (ii) Aviva will pay to the above bank account for future claims under this policy(ies). If there is a change of bank account, please notify Aviva.		

Section C: Claimant's Declaration on Beneficial Owner (please tick the box as appropriate)

Note: This is only applicable if the recipient of the proceeds is a legal person or a legal arrangement.

I/We declare that there is no change in Beneficial Owner(s).

Otherwise, please submit the Declaration of Beneficial Owner Form together with this form if there is any change in the Beneficial Ownership. You may find the Declaration of Beneficial Owner Form in our Aviva website www.aviva.com.sg.

"Beneficial owner" means the natural person who ultimately owns or controls the customer or the natural person on whose behalf business relations are established and includes any person who exercises ultimate effective control over a legal person or legal arrangement.

"Legal person" means an entity other than a natural person that can establish a permanent customer relationship with a financial institution or otherwise own property.

"Legal arrangement" means a trust or other similar arrangement.

Section D: Declaration and Authorisation

I/We, hereby declare that the answers given by me/us in this Form are in every respect true and correct and that no material information or circumstance has been withheld or omitted.

I/We, declare that I/We am/are not an undischarged bankrupt. There are currently no actual or pending bankruptcy proceedings against me/us and I/We have not assigned the Policy to any other party.

I/We agree that:

- a) this claim signifies my/our consent to Aviva Ltd to obtain medical information from any doctor whom the Life Assured has consulted and I/We authorise the doctor to release such information to Aviva.
- b) Aviva may release any relevant information concerning the Life Assured (including medical information) to any third party, which Aviva deems necessary.
- c) any third party has received any information concerning the Life Assured may also obtain medical information from any doctor whom I/We have consulted, and I/We authorise the doctor to release such information to the third party. The third party may also release relevant information concerning the Life Assured (including medical information) to any other party for any purposes related to the Life Assured's application or my/our claim for the benefits.
- d) a photocopied copy of this form shall be treated as valid and binding as if it is the original.

On behalf of myself and the Life Assured, I/We consent to Aviva (and Aviva related group of companies) collecting, using and/or disclosing the Life Assured and my/our personal data (whether contained in this form or obtained from other sources; existing data in Aviva's record or to be collected in future) for the following purposes:

- a) to issue and administer the Life Assured and my/our existing and/or new policy(ies) and/or account(s) with Aviva and such other purposes ancillary or related to the administering of the policy(ies) and/or account(s), including the processing of my/our personal data for underwriting purposes, payment of premiums (including, where applicable, the deduction of premiums due from the Medisave accounts of the Life Assured) and/or claims purposes;
- b) for statistical, research, compliance, audit and regulatory purposes; and
- c) to provide general information on product enhancements and services relevant to my/our needs or policies (including increasing benefits, adding riders/supplements and/or the Life Assured) as well as to provide financial advice or product recommendations to me/us, where applicable.

On behalf of myself and the Life Assured, I/We also consent to Aviva (and Aviva related group of companies) disclosing and transferring my/our personal data to (i) Aviva related group of companies and their respective third party service providers, reinsurers, suppliers and intermediaries; (ii) the Government of Singapore; (iii) statutory boards; and (iv) organisations approved by the Government of Singapore, whether located in Singapore or elsewhere, for the above purpose and such other purposes as described in Aviva's Personal Data Protection Statement ("Statement").

For a copy of the Statement and more information on Aviva's data protection policy and full details of the purpose of collection, use and disclosure of your personal data, please visit <http://www.aviva.com.sg/pdpa.html>

Signature of Assured

Signature of Life Assured*

Name of Assured

Name of Life Assured

NRIC/FIN/PP No.....

NRIC/FIN/PP No.....

Address.....

Address.....

.....

.....

Mobile No#.....

Mobile No#.....

Home No.....

Home No.....

Email#.....

Email#.....

Date (DD/MM/YYYY).....

*Signature of Life Assured is required if Life Assured is 21 years old and above

Note: #Mobile number and email address provided under Section D will replace our records accordingly.



SECTION E: DOCTOR REPORT (TO BE COMPLETED BY THE ATTENDING DOCTOR / SURGEON)

(Note: The medical report fee, if any, will be borne by the claimant.)

Patient's Name:		NRIC/FIN/Passport No:	Date of Treatment:
1) Final Diagnosis:	2) ICD10 Code:	3) Date of Diagnosis:	
4) Underlying Cause(s) of the Illness / Injury:	5) Other Diagnosis (including ICD10 Code):		
6) Is the condition / treatment / surgery related to any of these? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide more details:	<input type="checkbox"/> Pregnancy or Childbirth <input type="checkbox"/> Abortion or Miscarriage <input type="checkbox"/> Infertility or Sub-fertility Condition <input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> Congenital Anomaly <input type="checkbox"/> Genetic or Chromosomal Disorder <input type="checkbox"/> Mental or Psychiatric Condition <input type="checkbox"/> Cosmetic Reason	
7) When did the patient first consult you for this condition?	8) How long has the condition existed prior to consulting you?		
9) Approximate date of discovery of the condition:	10) Given the aetiology of the condition, please state the estimated date of such condition would be in existence:		
11) What were the symptoms / complaints prior to consulting you?	12) Please give the date the symptoms first started.		
13) If there is no symptom presented, what prompted the patient to see you?			
14) Has the patient ever had the same or similar condition / symptom? If "Yes", please indicate the date of occurrence and describe: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not to my knowledge			
15) Was the patient referred to you by another doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide a copy of the referral letter and the following information: <u>Name of Doctor</u> <u>First Consultation Date</u> <u>Name of Clinic</u> <u>Address</u>			
16) Did the patient ever consult any other doctor(s) previously for the above condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not to my knowledge If "Yes", please provide the following information: <u>Name of Doctor</u> <u>First Consultation Date</u> <u>Name of Clinic</u> <u>Address</u>			
17) Please provide us with the patient's regular doctor's name, clinic and address. <u>Name of Doctor</u> <u>Reason for consultation(s)</u> <u>Name of Clinic</u> <u>Address</u>			
18) Is the patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please state the estimated duration that patient needs to follow up with you. If "No", please give date of last visit.		19) Please provide the following if patient was referred to another doctor. a) Doctor's Name & Clinic: b) Reason for Referral: c) Date of Referral:	
20) Does the patient suffer from any other medical condition(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please state the medical condition(s) and the date of diagnosis:			
21) Please state the surgical procedure(s) performed. If there's no surgical procedure, please state the treatment / medication given.		22) If surgical procedure(s) was performed, please provide the following: <u>Surgical Procedure Code</u> <u>Date ((DD/MM/YY))</u> <u>Name of Surgeon</u>	
23) If excision was performed, please state the size of the lesion / tumor and provide a copy of the Histology Report.			
I hereby declare that the above answers are true to the best of my knowledge and belief.			
_____ Name and Designation		_____ Signature of Physician / Surgeon	
_____ Name and Address of Clinic / Hospital & Stamp		_____ Date (DD/MM/YY)	