880101

GROUP MEDICAL INSURANCE CLAIM FORM

AVIVA LTD
Group Life & Health Claims
4 Shenton Way, #01-01 SGX Centre 2
Singapore 068807
Tel: 6827 8030 Fax: (65) 6827 7705
Company Registration No.196900499K

SECTION 1 : TO BE COMPLETED BY POLICYHOLDER OR INSURED PERSON

Help us To Serve YOU Better – Contact & Payment Details			
Policy No:	Name of Company:		
Best way to contact you Please Tick ☑ (at least one or both)	☐ Mobile:	☐ Email:	Address of Employee:
Your Bank Details for Direct Credit	Bank Name:	Branch Code:	Bank A/C No:
*Note : Payment will not be made to employee unless prior arrangements was made by your employer with Aviva Ltd.			
Type of Claim – Please Tick ☑ (One Claim Per Member)	☐ Inpatient	☐ Outpatient	

About YOU – To Be Completed by Employee				
Name:		NRIC:	Employee ID:	
Gender: ☐ M ☐ F Please Tick ☑	Date of Birth:	Date of Employment:	Occupation:	Nationality:

About YOUR Dependant – Applicable For Dependant Claim ONLY			
Name:		NRIC:	Date of Birth:
Gender: ☐ M ☐ F Please Tick ☑	Nationality:	Relationship to Employee: Please Tick ☑ ☐ Child / ☐ Spouse	Occupation:

Please Tick ☑ ☐ **Illness**	Please Tick ☑ ☐ **Accident**
Nature of Illness:	Accident Date & Time: Brief Description of Accident:
Nature of Operation (**Applicable if there is surgery performed**):	
Date of FIRST Treatment:	
Name of Referring Doctor (**NOT APPLICABLE for GP Visit**):	
Were you / your dependant hospitalised as a result of an illness or accident? ☐ Yes ☐ No If yes, please provide the Date of Admission & Date of Discharge below	
Date of Admission:	Date of Discharge:

CONSENT & AUTHORISATION

This part must be signed by the patient's parent / legal guardian if patient is below 21 years old.

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

I/We consent to Aviva (and Aviva related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s), my/our insurance coverage and/or managing my/our relationship with Aviva.

I/We also consent to Aviva (and Aviva related group of companies) transferring my/our personal data to Aviva related group of companies and/or third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

For full details of the purposes of collection, use and disclosure of your personal data, please visit http://www.aviva.com.sg/pdpa.html.

_____ Signature of Employee	_____ Signature of Patient (For Dependant)	_____ Date

For Your EMPLOYER (NOT APPLICABLE FOR NAMED BASIS COVER)		
Effective Date of Coverage:	Date of Employment:	Plan:
Company Name & Stamp:	Signature of Employer:	Date of Signature: