AXA INSURANCE PTE LTD
8 Shenton Way #24-01 AXA Tower
Singapore 068811

Tel: (65) 6338 7288 Fax: (65) 6338 2552 www.axa.com.sg

Please complete this claim from fully. Incomplete forms may delay claim settlement

Please send claim form and documents to:

AEGIS INSURANCE AGENCIES PTE LTD
15 Queen Street, #03-07 Tan Chong Tower
Singapore 188537
Tel: (65) 6837 0306 Fax: (65) 6837 0305
Email: customerservice@aegisic.com
www.aegisic.com

COMBINED CLAIM FORM

TYPE OF CLAIM & CHECKLIST (please select)

☐ **Hospitalisation & Surgical**
- ☐ Completed Claim Form
- ☐ Original Final Medical Bills & Receipts
- ☐ Medical Report/Discharge Summary/Day Surgery Authorisation Form

☐ **Personal Accident**
- ☐ Completed Claim Form
- ☐ Original Medical Bills & Receipts
- ☐ Doctor's Memo providing description injury & treatment (if available)
- ☐ Police Report (for traffic accidents)

☐ **Outpatient GP / A&E**
- ☐ Completed Claim Form
- ☐ Original Medical Bills & Receipts

☐ **Outpatient Specialist**
- ☐ Completed Claim Form
- ☐ Original Medical Bills & Receipts
- ☐ Referral Letter from GP
- ☐ Doctor's Memo providing description of condition & treatment (if available)

PEI Name : **Policy Number(s) :**

SECTION A DETAILS OF INSURED PERSON (STUDENT)

Name of Insured Student (**as per bank account**)	Passport No.	Student ID No/FIN No.	Date of Admission to School
Please tick to select status ☐ Full Time Student ☐ Part Time Student	Please tick to select status ☐ Singapore Citizen/PR ☐ International (non STP) ☐ International (STP)		
E-mail	Telephone No.	Date of Birth	Gender ☐Male ☐ Female
Address (in Singapore)	Please settle claim payment by : ☐by cheque to student ☐by cheque to school		

SECTION B DETAILS OF ILLNESS

1. Nature of Illness/Symptoms/Final Diagnosis	2. Date Symptoms First Noticed	
3. Type of Treatment/Operation	4. Date First Treated	5. Hospitalisation Period

SECTION C DETAILS OF ACCIDENT

1. Description of Accident (how it happened)	2. Place of Accident	3. Date of Accident	4. Time of Accident
5. Nature of Injury	6. Treatment/ Operation	**7.** Hospitalisation Period	8. Is this a job-related injury ☐No ☐ Yes

SECTION D OTHER INFORMATION

1. Has the illness been treated before? Has the same part been injured before? ☐ No ☐ Yes, please state date first occurred	2. Are you making a claim for this treatment from any other insurance company? ☐No ☐ Yes, please provide settlement advice from the insurer
3. Name & Address of Attending Doctor/Clinic/Hospital	

SECTION E DECLARATION, AUTHORISATION & CUSTOMER'S DATA PRIVACY CONSENT

Declaration] 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 true and correct.

[Authorization] I/We hereby consent to and authorize the medical practitioner involved in the claimant's care to discuss and disclose treatment details and discharge arrangements with and to AXA Insurance Pte Ltd. I/We agree that a copy of this consent shall have the validity of the original.

[Customer's Data Privacy Consent] In connection with my claim, I give consent for AXA Insurance Pte Ltd ("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, 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 and their respective representatives or agents to provide me (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/ or managing my claims or the Policyholder Policy 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 Insured Student	Date

TO BE COMPLETED BY SCHOOL/PRIVATE EDUCATION INSTITUTION

Is student registered with PEI on date of accident/illness? ☐No ☐Yes	Verified and Witnessed by PEI: Sign & Stamp	Name of Authorised Officer (PEI): Designation of Authorised Officer (PEI):

redefining / insurance

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Co.Reg No. 199903512M

Medical Report

Policy No.

To be completed by your treating doctor if you have attended a private hospital or a hospital outside Singapore

1. Name of Patient

2. NRIC/FIN/Passport No.

3. Date admitted (DD/MM/YYYY) Date discharged (DD/MM/YYYY)

4. Was patient referred to you by another doctor? ☐ Yes ☐ No

   If "Yes", please state date of referral and provide us with the name and address of referring doctor.

   Date of Referral (DD/MM/YYYY) Name of Doctor and address of clinic

5. When did patient first consult you for the condition? Date of first consultation (DD/MM/YYYY)

6. What were the complaints or symptoms presented during the first consultation?

7. When did patient first experience these complaints or symptoms? Date of first consultation (DD/MM/YYYY)
   If there were no complaints or symptoms, what prompted the patient to see you?

8. In your expert opinion, per history provided to you by patient and given the etiology of the condition, please state the estimated duration of such condition would be in existence for this patient.

9. Has patient received any prior treatment for these complaints or symptoms? ☐ Yes ☐ No

   If "Yes" please state when and provide us with the name and address of doctor who treated patient previously.

10. Principal Diagnosis

Diagnosed Condition(s)	ICD 10 Code	Date of First Diagnosis (DD/MM/YYYY)	Date Patient Informed of Diagnosis (DD/MM/YYYY)

Other diagnosis(es)

Diagnosed Condition(s)	ICD 10 Code	Date of First Diagnosis (DD/MM/YYYY)	Date Patient Informed of Diagnosis (DD/MM/YYYY)

Note: If there is more than one diagnosis, please advise whether they are related directly to each other. If yes, please provide us with details to your answer.

☐ Yes ☐ No

11. What was the underlying cause(s) of the diagnosed condition(s) as stated in Question 10?

12. Did patient suffer or is suffering from any other co-morbidity (ies) that is/are related to diagnosed condition(s)?

☐ Yes ☐ No If 'Yes', please specify

Co-morbidity(ies)	Date of treatment	Name and address of doctor

13. Was surgery performed for the diagnosed condition(s)?

☐ Yes ☐ No If 'Yes', please specify

Date of Surgery	TOSP Code	Table	Description

14. If 2 or more surgeries were performed, please specify whether they were done through same incision.

15. If no surgery was performed, please state treatment and medication given.

If patient was admitted for a maternity condition, please complete this section

16. a) Patient's LMP (DD/MM/YYYY)

b) Is the pregnancy a result of any infertility treatment including infertility medication or conception by artificial means?

☐ Yes ☐ No If "Yes", please provide details to your answer

c) Type of delivery ☐ Vaginal Delivery ☐ Elective Caesarean Section ☐ Emergency Caesarean Section

If Emergency Caesarean Section, please advise reason(s)

d) Did any complications arise during pregnancy? ☐ Yes ☐ No If 'Yes', please provide details to your answer

If patient was admitted for miscarriage, please complete this section

17. Was it due to an accident? ☐ Yes ☐ No

If yes, please describe how it happened?

If no, please state the cause of the miscarriage?

If patient was admitted due to an accident, please complete this section

18. Was the treatment related to accident? ☐ Yes ☐ No

Date of accident (DD/MM/YYYY)

☐ Road traffic accident ☐ Work related accident ☐ Others If 'Others', please specify

Please describe how it happened?

Was patient's diagnosed condition(s)/ surgery(ies)/ treatment due to or related to any of the following

19.

Dental condition	☐ Yes ☐ No	A psychiatric condition	☐ Yes ☐ No
Abortion	☐ Yes ☐ No	Alcohol Dependence/Substabce Abuse	☐ Yes ☐ No
Infertility/Sub-fertility/ Impotence/ Contraception/ Sterilisation	☐ Yes ☐ No	Sleep Apnoea/Sleep Disorder	☐ Yes ☐ No
		Self-inflicted injury/Attempted Suicide	☐ Yes ☐ No
Sexually transmitted disease	☐ Yes ☐ No	Refractive error of the eye(s)	☐ Yes ☐ No
AIDS or HIV	☐ Yes ☐ No	Obesity/ Weight Reduction/Weight Improvement	☐ Yes ☐ No
A congenital condition	☐ Yes ☐ No		
Learning disorder/Behavioural problem/Physical & Psychological development problem			☐ Yes ☐ No

20. Was the treatment a/ an

☐ Experimental medical treatment ☐ Cosmetic/ Plastic surgery

If you have ticked any boxes, please give details of the treatment(s)/surgery(ies).

21 Any other information that may assist us in the assessment of the claim.

I hereby certify that I have personally examined and treated the patient in connection to the above condition(s) and the facts as given above represent my opinion of his/ her condition. I declare and agree to make the declaration on this claim form.

_____	_____
Signature of Doctor	Date
_____	_____
Name of Doctor	Hospital/Clinic stamp