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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.

Important Notes

- The acceptance of this Claim Submission is NOT an admission of liability on the part of AXA Insurance Pte Ltd ("AXA"). Any documentary proof or medical report required by AXA Insurance shall be furnished at the expense of the Policyholder/Life Insured;
- AXA will accept copies of final medical bills / invoices / receipts / tax invoices. Please retain your original documents for 6 months from the submission date as AXA reserves the right to call for the original documents.
- In the event the original final invoices / bills / receipts / tax invoices are not available should AXA call for them, AXA will request a declaration from the Policy Holder / Employee. If there are any double claims, AXA reserves the right to recover any claims from the Policy Holder / Employee.
- If you are submitting a duplicate bill (as stated on the bill), please complete and submit the Letter of Undertaking to AXA with your claim(s) submission.
- **Important: For any Inpatient / Day Surgery claim incurred outside Singapore, please submit the original final medical bills / invoices / receipts.**

Checklist for Outpatient / Inpatient Claims: Please put a cross ☐ against the documents you are submitting.

(I) 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:

- ☐ Duly completed and signed claim form (Part 1)
- ☐ Copy of 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)
- ☐ Copy of Referral Letter from GP to Specialist / Hospital **OR** Copy of appointment card from Specialist / Hospital
- ☐ Copy of any referral form for laboratory / blood test / x-rays
- ☐ Copy of CPF Medisave [1]
- ☐ Claim Settlement Advice from any 3rd party payee (if any).

(II) For Inpatient Claims

Please submit the following documents within one month from date of discharge from hospital:

Admission to Government / Restructured Hospital:

- ☐ Duly completed and signed claim form (Part 1)
- ☐ Copy of final hospital bills, doctors' bills and receipts
- ☐ Inpatient Discharge Summary / Day Surgery Admission Form / Ambulatory Form / Pre- Admission Form
- ☐ Copy of CPF Medisave [1]
- ☐ Claim Settlement Advice from any 3rd party payee or Medisave-approved Integrated Shield Plan (if any) – example, AXA Shield, AIA Healthshield, NTUC Incomeshield, AVIVA Myshield, Prudential Prushield or Great Eastern Supremehealth

Admission to Private Hospitals / Clinics

- ☐ Duly completed and signed claim form (Part 1) and Medical Report (Part 2)
- ☐ Copy of final hospital bills, doctors' bills and receipts
- ☐ Inpatient Discharge Summary / Day Surgery Admission Form / Ambulatory Form / Pre- Admission Form
- ☐ Copy of CPF Medisave [1]
- ☐ Claim Settlement Advice from any 3rd party payee or Medisave-approved Integrated Shield Plan (if any) – example, AXA Shield, AIA Healthshield, NTUC Incomeshield, AVIVA Myshield, Prudential Prushield or Great Eastern Supremehealth

Admission to Hospitals outside Singapore

- ☐ Duly completed and signed claim form (Part 1) and Medical Report (Part 2)
- ☐ All Original Final Summary and Itemized Hospital Bills, Doctors' bills, receipts and translation of all documents
- ☐ Inpatient Discharge Summary / Day Surgery Admission Form
- ☐ Claim Settlement Advice from any 3rd party payee (if any)

(III) Maternity Claims

- ☐ Duly completed and signed claim form (Part 1) and Medical Report if discharge summary is not available (Part 2)
- ☐ Copy of final hospital itemised bills, doctors' bills, receipts, translation of all documents into English for overseas hospital
- ☐ Copy of CPF Medisave [1]
- ☐ Claim Settlement Advice from any 3rd party payee (if any)

[1] Copy of CPF Medisave Transactions Statement with **HRN No (Hospital Reference Number)** if you have utilized your Medisave to make payment. You may obtain a copy of this Statement from www.cpf.gov.sg, go to "My Statement" and click on "Section B – Medisave and/or MediShield Life to view payment details.

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FOR EMPLOYEE BENEFITS CLAIMS DEPT USE ONLY:

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Employee Benefits Group Medical Insurance Claim Form

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

☐ Outpatient GP ☐ Outpatient SP / XRLB ☐ Dental ☐ Maternity ☐ 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 OF TAX INVOICES

Have you claimed or do you intend to claim from any insurer or any 3rd parties for the reimbursement of your medical bills? ☐ **Yes** ☐ **No**

If 'yes', please state the party that you are claiming from and submit a copy of the settlement letter or payment voucher from the other party. ______________________________

Note: It is important that you inform us if you are claiming from any insurer or any 3rd party for the same bill(s). You can only be reimbursed once for the amount that you have incurred regardless of the number of medical insurance policies you may have. We reserve the rights to recover if there is any excess amount paid to you.

E. 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)

F. 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 / Clinic or Hospital / Clinic 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) Employee 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?

6) Is the condition / treatment related to:

		Yes	No
a)	Pregnancy or childbirth	☐ Yes	☐ No
b)	Abortion / Miscarriage	☐ Yes	☐ No
c)	Impotency	☐ Yes	☐ No
d)	Sterilisation	☐ Yes	☐ No
e)	Infertility or Sub-fertility Condition	☐ Yes	☐ No
f)	Congenital Anomaly	☐ Yes	☐ No
g)	Genetic	☐ Yes	☐ No
h)	Hereditary	☐ Yes	☐ No
i)	Chromosomal Disorder	☐ Yes	☐ No
j)	STD	☐ Yes	☐ No
k)	AIDS and Illness or Disease rela	☐ Yes	☐ No
l)	Cosmetic Surgery	☐ Yes	☐ No
m)	Mental / Psychiatric Condition	☐ Yes	☐ No
n)	Self-inflicted injury	☐ Yes	☐ No
o)	Drug Addition / Alcoholism	☐ Yes	☐ No
p)	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 & Designation
Name:
Date:

____
Name and address of Hospital / Clinic & 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) Employee Name: Company Name:

CLAIMS DETAILS

3) Date of consultation

4) Complaints and/or symptoms:

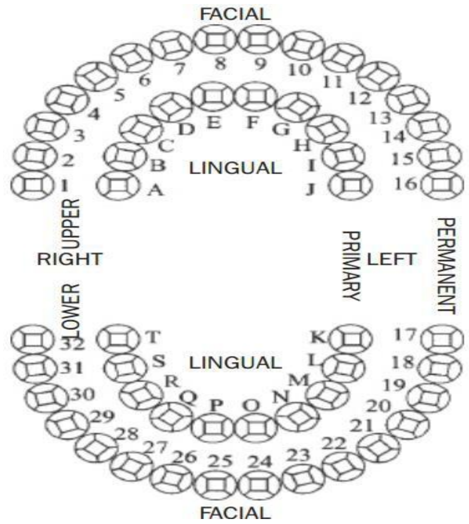
5) Nature of treatment. Please tick (❑) where appropriate:

☐ 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 Hospital / Clinic & stamp