COMBINED CLAIM FORM

AXA INSURANCE SINGAPORE PTE LTD
143 Cecil Street #01-01 GB Building
Singapore 069542
Tel: (65) 6338 7288 Fax: (65) 6338 2522 www.axa.com.sg

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

Please send claim form and documents to:

AEGIS INSURANCE SERVICES 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

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 : ☐credit to student's bank* ☐by cheque to student ☐others _____ (*for outpatient claims only if applicable)		

SECTION B DETAILS OF STUDENT'S BANK ACCOUNT - Please complete if you tick claim payment by credit to student's bank (For Outpatient claims only)

Bank Name (please tick) ☐ DBS/POSB ☐ UOB ☐ OCBC ☐ others	Branch	Account No. | | | | | | | | | | | | | |

SECTION C 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 D 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 E 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 state name of insurer

3. Name & Address of Attending Doctor/Clinic/Hospital

SECTION F DECLARATION & AUTHORISATION

I hereby authorise any hospital, physician, person or organisation who has attended to or examined me, or is authorized to maintain medical records, to disclose when requested to do so by AXA Insurance Singapore Pte Ltd any and all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.
I hereby declare that the above information, statements answers are true and complete to the best of my knowledge and belief. I agree that if I have made, of if I shall make, any false or untrue statement, suppression or concealment, the Policy shall be void and all rights to compensation shall be absolutely forfeited.

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):

MEDICAL CERTIFICATION OF TREATMENT

SPECIAL INSTRUCTION:
(GROUP SCHEME MEMBERS): Please arrange for this Medical Certification of Treatment to be completed by your treating doctor if you have attended a Private Hospital or Hospital outside Singapore.

(INDIVIDUAL SCHEME MEMBERS): Please arrange for this Medical Certification of Treatment to be completed by your medical practitioner for treatment in all hospitals.

1. Name of patient:	**NRIC:**
2. Full description of diagnosis (based on ICD, 1975 revision, WHO) a) Principal diagnosis: b) Other diagnosis:	 ICD CODE ☐☐☐☐ ICD CODE ☐☐☐☐
3. What is the cause of the illness/injury? _____	
4. Has the patient suffered or is sufering from any other medical condition(s) that is/are related to the diagnosis in Question 2? If yes, please give details & when the condition(s) manifested. _____ _____	☐ YES ☐ NO
5. Is this treatment related to: i) Sleep Apnea ii) Obesity iii) Weight Reduction/Improvement	☐ YES ☐ NO
6. Is this treatment related to a) pregnancy or childbirth? b) abortion or miscarriage? If related to miscarriage, was it due to accident?	 ☐ YES LMP: ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO
7. Will the patient be required to undergo a) Normal Delivery b) Elective Caesarean If Elective Caesarean, please state the reason. _____ _____	 ☐ YES ☐ NO ☐ YES ☐ NO
8. Is this treatment a) related to infertility/subfertility condition? b) done to correct infertility/subfertility condition?	 ☐ YES ☐ NO ☐ YES ☐ NO
9. Is this due to self-inflicted injury or sexually transmitted disease?	☐ YES ☐ NO
10. Is this condition a) a congenital anomaly? b) a mental or nervous disorder? c) a refractive error of the eye?	 ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO

11. Is this a) a cosmetic surgery? If No, Please explain_____ b) an oral surgery? c) a dental surgery/treatment?	☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO
12. Is this a job-related injury?	☐ YES ☐ NO
13. Has the patient ever had the same or similar condition / symptoms? If yes, please indicate when and describe.	☐ YES ☐ NO
14. Doctors previously consulted by the patient for the above condition(s).	
15. Please indicate approximate date from which the patient first notice symptoms of condition.	DD | MM | YYYY
16a. What symptoms did the patient present?	
16b. How long had the patient been troubled by them?	DD | MM | YYYY
17. Date you were first consulted for this condition.	
18a. Date of diagnosis for this condition.	DD | MM | YYYY
18b. Date patient was informed of your diagnosis	DD | MM | YYYY
19. How long had has the injury / illness been existing prior consulting you?	

20. Surgical operations performed on patient

*Operation Code	Type of Operation	*Table	Date Performed
☐☐☐☐☐☐	_____	_____	DD | MM | YYYY
☐☐☐☐☐☐	_____	_____	DD | MM | YYYY
☐☐☐☐☐☐	_____	_____	DD | MM | YYYY

_____
Date

_____
Signature of Physician/Surgeon and Official Stamp.

Name of Physician/Surgeon
Address

* This applies to operations carried out in S'pore only and refers to the classification in the Medisave table of surgical operations for private hospital.