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

HOW TO FILE A GROUP MEDICAL INSURANCE CLAIM

For Outpatient Claims, please assist to submit the following : -

a) Duly completed Claim Form (Section 1)
b) All original final hospital tax invoices, doctor's bill and receipts
c) Referral Letter from General Practitioner (GP) to Specialist / Hospital
d) Any referral form for Laboratory / Blood Test
e) Copy of appointment card to Specialist / Hospital

For Inpatient Claims, please assist to submit the following : -

a) Duly completed Claim Form (Section 1)
b) All original final hospital, doctor's bill and receipts. For admission / surgery at Private Hospital / clinics, please provide Original Final Summary Hospital Bill and Original Final Itemised Hospital Bill.
c) Refer to the guidelines ** below on the requirement for completion of Section 2 of the Claim Form
d) Other additional supporting documents (if any) on the medical condition that can assist in the assessment of the claims:
   – Inpatient Discharge Summary
   – Ambulatory Form / Pre Admission Form
   – Referral Letter from General Practitioner (GP) to Specialist / Hospital
   – Any referral form for Laboratory / Blood Test
e) For follow up visits following your hospitalisation / surgery claim, simply let us have your original bills & receipts. Group Medical Insurance Claim Form is not required.

Note : The Insured Member is required to furnish us the above documents within one month of discharge from the hospital.

** <u>GUIDELINES FOR THE REQUIREMENT OF MEDICAL REPORT</u>

The following procedure applies to claimants who are admitted into various hospitals:

Hospitalisation at	Medical Report to be applied by :	Procedures	Cost of Medical Report to be borne by Aviva Ltd :
Private Hospitals	Claimant	To submit Section 2 of the Claim Form duly completed by the Attending Physician / Surgeon to Aviva Ltd	Nil
*AH, *CDC, *CGH, *KKH, *KTP, *NCC, *NHC, *NSC, *NUH, *SGH, *SNEC, *TTSH, & other Singapore Govt./Restructured Hospitals	Aviva Ltd	Aviva Ltd will apply for the report, where necessary. The report fee in excess of S$75 will be recovered from the client once the claim has been processed.	S$75/-

*AH – Alexandra Hospital
*CDC – Communicable Disease Centre
*CGH – Changi General Hospital
*KKH – KK Women's and Children's Hospital
*KTP – Khoo Teck Puat Hospital
*NCC – National Cancer Centre
*NHC – National Heart Centre
*NSC – National Skin Centre
*NUH – National University Hospital
*SGH – Singapore General Hospital
*SNEC – Singapore National Eye Centre
*TTSH – Tan Tock Seng Hospital

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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:

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SECTION 2: MEDICAL REPORT (TO BE COMPLETED BY ATTENDING PHYSICIAN / SURGEON)
For admission to Private Hospital or Hospital outside Singapore, claimant must arrange to have this section completed by the Attending Physician when submitting a claim.

Patient Information		
Policy No:	Name of Company:	
Name of Patient:	NRIC/Passport No:	Admission Period:

Nature of Illness	Nature of Treatment / Surgery
01) Final Diagnosis (Based on ICD 10) of illness or extend of Injury DRG Code ☐☐☐☐ ICD Code ☐☐☐☐ ICD Code ☐☐☐☐ Date of Diagnosis: _____	05) Date of surgical procedure or treatment rendered : _____ Operation Code ☐☐☐☐☐☐ Operation Table ☐☐
02) Given the aetiology of the condition, please state the estimated date of such condition would be in existence.	06) Describe the surgical procedure or treatment rendered. If no surgery was performed, please state treatment / medication given
03) What is the cause of illness / injury?	07) If excision was performed, please indicate the size of the lesion / tumor. (Please attach a copy of the Histology Report)
04) What is the anatomy of this illness?	08) Name of a) Physician _____ b) Surgeon _____ c) Anesthetist _____
09) Is the condition/treatment related to:	Yes / If "Yes", please elaborate. / No
a) Pregnancy or childbirth	☐ _____ ☐
b) Abortion or Miscarriage	☐ _____ ☐
c) Infertility or Sub-fertility Condition	☐ _____ ☐
d) Congenital Anomaly	☐ _____ ☐
e) Genetic or Chromosomal Disorder	☐ _____ ☐
f) Mental or Psychiatric Condition	☐ _____ ☐
g) Cosmetic Surgery	☐ _____ ☐
h) Is the surgery for correction of short sightedness?	☐ _____ ☐
i) Is the surgery for dental purposes?	☐ _____ ☐
Medical History	
10) Please provide the name and address of referring doctor if patient was referred to you.	15) If there is no symptoms presented, what has prompted the patient to see you?
11) When did the patient first consult you for this condition?	16) Please specify the approximate date of discovery of the illness or injury
12) Nature and Date of Treatment rendered	17) How long has the illness / injury existed prior to consulting you?
13) What were the symptoms/complaints prior to consulting you?	18) Has the patient ever had the same or similar condition / symptom? ☐ Yes ☐ No ☐ Not to my knowledge
14) Please indicate the nature of Symptoms and date Symptoms first started	19) Doctors previously consulted by the patient for the above condition. Name of Doctors: _____ First Consultation: _____ Name of Clinic: _____ Address: _____
20) Is the patient still under your care for this condition? ☐ Yes ☐ No If Yes, please state the estimated duration that patient needs to follow up with you.	If No, please give termination date of service and furnish name and address of doctor if the patient has been referred to another doctor for follow up

_____ Signature of Physician / Surgeon

_____ Date

_____ Name / Designation

_____ Name and Address of Clinic / Hospital & Stamp