* C L A I M F *

AVIVA

RETAIL & INDIVIDUAL MEDICAL CLAIM FORM

IMPORTANT: Please furnish the following documents to Aviva Ltd for your medical claim:

1. Completed Claim Form
2. Original Final Bills
3. Copy of the Inpatient Discharge Summary, diagnostic reports, laboratory evidence and any relevant hospital reports that are available.
4. For hospitalization or day surgery claim, Section E of the Claim Form needs to be completed by the attending doctor/surgeon at the expense of the claimant.

Please tick (✔) the appropriate box: ❒ MyShield / MyHealthPlus Claim ❒ Other Medical Plan **Policy No.**_____

Section A: Details of Assured (Policyholder) & Life Assured

Name of Assured (Policyholder)	NRIC/FIN/Passport No.	
Occupation	Date of Birth	Gender
Name of Life Assured	NRIC/FIN/Passport No.	
Occupation	Date of Birth	Gender

Details of Illness / Injury

1) Date symptoms 1st started	2) Describe the symptoms 1st presented
3) Date 1st consulted doctor for the condition	

4) Name & Address of the doctor 1st consulted for the condition

5) Final Diagnosis		6) Date of Diagnosis
7) Date of Admission	8) Date of Discharge	9) Date of Operation, if any

10) Name and address of doctor or specialist who attended to the Life Assured during his/her hospital's confinement

11) What was the treatment (including any surgery) given to the Life Assured?

12) Is the Life Assured also insured under an employer's group medical plan or any other medical plan? ❒ Yes ❒ No

Name of Insurance Company | Employer's Name (if applicable) | Policy No. (if any)

If the Illness/Injury resulted from an Accident, please complete this section.

1) Place of Accident	2) Date and Time of Accident
3) Describe in detail how the accident happened	4) Nature and extent of injuries

Aviva Ltd | 4 Shenton Way #01-01 SGX Centre 2 Singapore 068807 | Tel: (65) 6827 7988 | Fax: (65) 6827 7900
Website: www.aviva.com.sg | Company Reg No.: 196900499K | GST Reg.No.: MR-8500166-8

Section B: Assured's (Policyholder's) Bank Account Details (please complete if you would like us to pay your claim via EFT)

Name of Bank:_____ Branch Code:_____ Bank Account No:_____
(Excluding Branch Code)

Note: Aviva will pay to the above bank account for future claims under your individual **health policies only**. If there is a change of bank account, please notify Aviva.

Section C: Claimant's Declaration on Beneficial Owner (please tick the box as appropriate)

I/We declare that:

❒ there is no beneficial owner under this Policy.

❒ there is/are beneficial owner(s) under this Policy. (If you tick this box, please complete the table below*.)

*The following person(s) is/are the beneficial owner(s). A copy of each of the identity card(s)/passport(s) of the beneficial owner(s) is enclosed.

Name	NRIC/FIN/Passport No.	Relationship with Policyholder

"Beneficial owner" means the natural person who ultimately owns or controls the customer or the natural person on whose behalf business relations are established, and include any person who exercises ultimate effective control over a legal person or legal arrangement.

Section D: Declaration and Authorisation

I/We, hereby declare that the answers given by me/us in this Form are in every respect true and correct and that no material information or circumstance has been withheld or omitted.

I/We further consent to Aviva Ltd seeking information from any clinic, hospital, physician, person, organisation, employer that may be required in connection with this claim and I/we authorise the giving of such information to Aviva Ltd. A photocopy of this authorisation shall be considered as effective and valid as the original.

I/We consent to Aviva Ltd(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) and/or managing my/our relationship with Aviva Ltd.

I/We also consent to Aviva Ltd (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.

I/We confirm that I/we have read and agree to the terms of the Aviva Data Protection Policy (as amended, supplemented or substituted by Aviva Ltd from time to time) at http://www.aviva.com.sg/pdpa.html.

I/We declare that there is no change to the information that I/we have provided to Aviva Ltd that would result in a change to my/our tax residency status including but not limited to my/our status as a U.S. Person for U.S. federal income tax purposes, such as change in my/our residence/mailing/in-care of address telephone number and citizenship.

I/We undertake to inform Aviva Ltd in writing within 30 days of any change in circumstances which would affect my/our tax residency status.

Note: If you are filling up this form on behalf of another person or whereby you are disclosing personal data to us other than yours, you are required to inform such person(s) of the purpose and obtain his/her consent before submitting this form to us. Once you have submitted, you will be deemed to have obtained the necessary consent for us.

Signature of Assured ……	Signature of Life Assured * ……..
Name of Assured ……	Name of Life Assured ……
NRIC/FIN/PP No……	NRIC/FIN/PP No……
Address……	Address……..
……	……
Mobile No……..	Mobile No……..
Home No……	Home No……
Email……....	Email……..
Date (dd/mm/yyyy)……..	

Note: * Signature of Life Assured (if Life Assured is age 21 and above)

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* S U P D O C *

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SECTION E: DOCTOR REPORT (TO BE COMPLETED BY THE ATTENDING DOCTOR / SURGEON)

(Note: The medical report fee, if any, will be borne by the claimant.)

Patient's Name:	**NRIC/FIN/Passport No:**	**Admission Period:**
1) Final Diagnosis:	2) ICD10 Code:	3) Date of Diagnosis:
4) Underlying Cause(s) of the Illness / Injury:	5) Other Diagnosis (including ICD10 Code):	

6) Is the condition / treatment / surgery related to any of these? ☐ Yes ☐ No

If "Yes", please provide more details:

- ☐ Pregnancy or Childbirth
- ☐ Abortion or Miscarriage
- ☐ Infertility or Sub-fertility Condition
- ☐ Sexually Transmitted Disease
- ☐ Congenital Anomaly
- ☐ Genetic or Chromosomal Disorder
- ☐ Mental or Psychiatric Condition
- ☐ Cosmetic Reason

7) When did the patient first consult you for this condition?	8) How long has the condition existed prior to consulting you?
9) Approximate date of discovery of the condition:	10) Given the aetiology of the condition, please state the estimated date of such condition would be in existence:
11a) What were the symptoms / complaints prior to consulting you?	11b) Please give the date the symptoms first started.

12) If there is no symptom presented, what prompted the patient to see you?

13) Has the patient ever had the same or similar condition / symptom? If "Yes", please indicate the date of occurrence and describe:

☐ Yes ☐ No ☐ Not to my knowledge

14) Was the patient referred to you by another doctor? ☐ Yes ☐ No If "Yes", please provide a copy of the **referral letter** and the following information.

Name of Doctor | First Consultation Date | Name of Clinic | Address

If "No", how did the patient come to know about your service?

15) Did the patient ever consult any other doctor(s) previously for the above condition? ☐ Yes ☐ No ☐ Not to my knowledge

If "Yes", please provide the following information:

First Consultation Date | Name of Doctor | Name of Clinic | Address

16) Please provide us with the patient's regular doctor's name, clinic and address.

Name of Doctor | Name of Clinic | Address | Reason for consultation(s)

17) 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 date of last visit.	18) Please provide the following information if patient was referred to another doctor. a) Doctor's Name & Clinic: b) Reason for Referral: c) Date of Referral:

19) Does the patient suffer from another other medical condition(s)? ☐ Yes ☐ No

If "Yes", please state the medical condition(s) and the date of diagnosis:

20) Please state the surgical procedure(s) performed. If no surgical procedure was performed, please state the treatment / medication given.	21) If surgical procedure(s) was performed, please provide the following information: Surgical Procedure Code | Date (DD/MM/YY) | Name of Surgeon

22) If excision was performed, please state the size of the lesion / tumor and provide a copy of the Histology Report.

Name and Designation	Signature of Physician / Surgeon
Name and Address of Clinic / Hospital & Stamp	Date (DD/MM/YY)

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