



redefining / insurance



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



Customer Care Team #B1-01
1800 880 4888



cst@axa.com.sg



www.axa.com.sg

Co. Reg No. 199903512M

SmartHelper Claim Form

Policy/ Certificate No.

Please answer in full all the applicable questions on this side of the form only and attach original bills which are eligible for benefit. Incomplete answers may delay claims settlement. Any interest charged by hospitals will be borne by the employer/member. Claims submitted later than 30 days of the expenditure being incurred may be declined for benefit payment.

A. Policy Information

Policyholder's Full Name	<input type="text"/>	NRIC/FIN No.	<input type="text"/>
Email	<input type="text"/>	Mobile No.	<input type="text"/>
Home Address	<input type="text"/>		
	<input type="text"/>		

Name of Patient (Domestic Helper)	<input type="text"/>		
Age	<input type="text"/>	Sex	<input type="text"/>
Date of employment	<input type="text"/>	Work Permit Number	<input type="text"/>

B. SICKNESS (THIS MUST BE ANSWERED IN FULL)

Diagnosis	<input type="text"/>		
Date Symptoms First Began	<input type="text"/>	Date First Treated	<input type="text"/>
Is the sickness arising from employment?	Yes <input type="checkbox"/>	No	<input type="checkbox"/>
Has the sickness been treated previously? If yes please state name and address of Physician.	Yes <input type="checkbox"/>	No	<input type="checkbox"/>
Date of Last Treatment	<input type="text"/>		
Is the sickness due to pregnancy, abortion, sterilization or infertility? If yes, specify condition and approximate date of commencement.	Yes <input type="checkbox"/>	No	<input type="checkbox"/>
Name and address of Hospital / Clinic:	<input type="text"/>		
	<input type="text"/>		

C. INJURY

Date of Accident	<input type="text"/>	Time of Accident	<input type="text"/>
Is this a job related Accident?	Yes <input type="checkbox"/>	No	<input type="checkbox"/>
Name and address of Hospital / Clinic	<input type="text"/>		
	<input type="text"/>		

D. BANK ACCOUNT DETAILS (for direct transfer to your bank account)

Name (as per bank account)

Bank Name

Bank Code

Account No.

Branch Code

E. EMPLOYER & PATIENT'S DECLARATION

I / We confirm that I / We am the patient and the patient's employer (respectively) and I / We declare that all the particulars given above are to the best of my / our knowledge true and correct. I / We hereby consent to and authorise the medical practitioner involved in the patient's care to discuss and disclose treatment details, medical history 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.

In connection with my / our claims, I / We give consent for AXA Insurance Ptd 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 / us, 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 related parties under this Policy) for the purpose of enabling AXA and their respective representatives or agents to provide me / us with services required of an insurance provider, including the evaluating, processing, administering and / or managing my / our claims or this 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").

Employer's Signature _____

Date _____

Patient's Signature _____

Date _____

F. Contact Us

If you have any questions regarding this form or any other aspects of the cover, please contact our Claims Service Team on 1800 880 4888 quoting your policy/certificate numbers. Claims must be submitted along with supporting documents within 30 days from date of service. Send this claim form together with supporting material to AXA Insurance Pte Ltd, 8 Shenton Way #24-01, AXA Tower, Singapore 068811.



www.axa.com.sg
(Claim Section)



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