AXA Insurance Pte Ltd
Tel: 68804888
Email: healthops@axa.com.sg

PART 1
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FORM
(To be completed by Insured Member)

A. ADMINISTRATIVE	
Policy Number:	**Policy Owner's Name:**
Patient's Date of Birth: **Gender:** M / F	**Patient's Full Name:**
Patient's NRIC / FIN / ID / Passport No:	**Date of Employment: (For Group Policy)**
Email Address:	**Patient's Contact Number:**

B. DECLARATION AND AUTHORIZATION

I confirm I am the patient / patient's parent / patient's spouse / patient's legal guardian* (circle where applicable) and wish to claim under the above policy and I declare that the statements stated are true and complete to the best of my knowledge and belief.

I hereby authorize AXA Insurance Pte Ltd or its representative(s) to request from any physician, hospital, dentist, person or organization (including the Policy Owner (the "Employer"), all information with respect to any illness, injury, medical history, consultations, billing information, prescriptions or treatment and copies of all hospital and medical records concerning me and/or the patient at any time and authorize the prior mentioned organizations to disclose all such information to AXA Insurance Pte Ltd or its representative(s). A photocopy of this authorization shall be considered as effective and valid as the original.

In connection with my and/or the patient's claims, I give consent for AXA Insurance Pte Ltd (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 and/or the patient, 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 Employer when claiming under a Group Policy) for the purpose of enabling AXA and their respective representatives or agents to provide me and/or the patient (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/ or managing my and/or the patient's 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").

Full Name: _____

NRIC / FIN / ID / Passport No: _____

Contact Number: _____

(Applicable if details are different from Section A and patient is a minor)

Patient's Signature: _____

Patient's Full Name: _____ Date: _____

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PART 2
PRE - ADMISSION FORM
(To be completed by Treating Doctor Only)

Patient's Full Name:	NRIC / FIN / ID / Passport No:
Date of Admission: DD / MM / YYYY	Admitting Hospital:

1. MEDICAL SECTION:

a. Symptoms Presented:	b. Admitting Diagnosis and ICD 10:
c. Date the patient first consulted you for this illness/injury? (DD / MM / YYYY)	d. Date the patient first became aware of any signs or symptoms for this illness/injury? DD / MM / YYYY
e. If this condition existed before symptoms became apparent to the patient, please indicate when, in your professional view this condition began to develop? DD / MM / YYYY	f. What is the cause of the illness/injury?

g. Any previous consultation, treatment, hospitalization for this illness/injury? If YES, please provide details as below:

Date	Details of treatment	Name of doctor	Hospital / Clinic contact details

2. Is the admitting diagnosis in relation to:	**If Yes, Please give details**
a. Pregnancy, Childbirth, Complication of Pregnancy?	☐ Yes ☐ No
b. Is Pregnancy a result from a natural conception?	☐ Yes ☐ No
c. Infertility, impotence, erectile dysfunction or any contraceptive treatment?	☐ Yes ☐ No
d. Sleep disorders, Sleep Apnea, Obesity or Weight management?	☐ Yes ☐ No
e. Self-inflicted injuries, injuries resulting from attempted suicide, alcohol /drugs/ substance abuse?	☐ Yes ☐ No
f. Sexually Transmitted Disease (STD), AIDS/any conditions resulting from or related to HIV?	☐ Yes ☐ No
g. Congenital anomalies, Psychiatric, Mental illness?	☐ Yes ☐ No
h. Work Related Accident / Injury?	☐ Yes ☐ No
i. Dental conditions, Cosmetic or Aesthetic?	☐ Yes ☐ No

3. TREATMENT DETAILS & COST ESTIMATES:

Treatment details or Surgical Procedure(s):

Surgical Operation Code(s) TOSP:

Hospital charges:	Surgery Fees:
Length of Stay (DAY):	Daily Attendance Fees:
Anaesthetist Fees:	Doctor Other Fee (please give details if any):

4. Please provide copies of Referral letter, Financial counseling, Diagnostic test results / reports

_____ **Signature of Treating Doctor & Official Stamp of Clinic/Doctor**	**Name of Treating Doctor:** **Date:**

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