redefining / insurance

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OUTPATIENT CLAIM FORM

Policy No.

☐ Outpatient Claim ☐ Pre- Hospitalisation Claim ☐ Post –Hospitalisation Claim ☐ Dental Claim

A. Employer (For Group Policy)

Full Name

B. Policyholder's (For Individual Policy) /Employee's (For Group Policy) Particulars

Full Name | NRIC/FIN/Passport No.

Date of Birth (DD/MM/YYYY) | Nationality

Contact Number (Mobile) | Gender ☐ Female ☐ Male

Email Address

C. Patient's Particulars (If Patient is a dependent of the Policyholder/Employee)

Full Name

Relationship ☐ Spouse ☐ Child | NRIC/FIN/Passport No.

Date of Birth (DD/MM/YYYY) | Gender ☐ Female ☐ Male

D. Please complete if Outpatient/Dental Claim was due to an Accident (if applicable)

Date of Accident (DD/MM/YYYY) | Time of Accident

Place of Accident

Describe how the accident happened (Please enclose a copy of the policy report, if any)

Describe in details the injuries sustained, indicating the part of the body injured and the type of injury (e.g. fracture, cut, bruise etc.)

Was it work related? ☐ Yes ☐ No

Are you entitled to claim against Work Injury Compensation? ☐ Yes ☐ No

E. Please provide details of outpatient claims (if applicable)

Date of Consultation (DD/MM/YYYY)	Date patient first experienced symptoms (DD/MM/YYYY)	Symptom(s) Presented	Diagnosis	Amount Incurred (Please state currency)

Was the patient ever hospitalized as the result of the above illness or accident? ☐ Yes ☐ No

If yes, please state the name of the hospital and the date(s) of admission & discharge

Name of the hospital

Date of Admission (DD/MM/YYYY)

Date of Discharge (DD/MM/YYYY)

F. Please provide details of dental claims (if applicable)

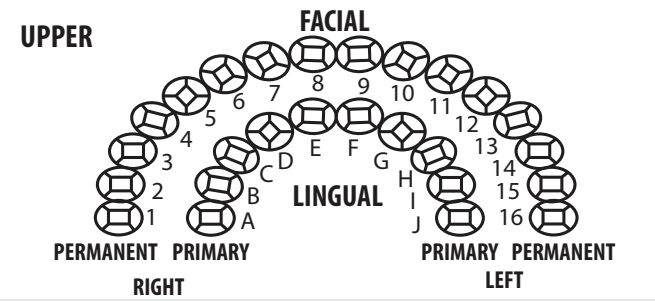
Date of Consultation (DD/MM/YYYY)

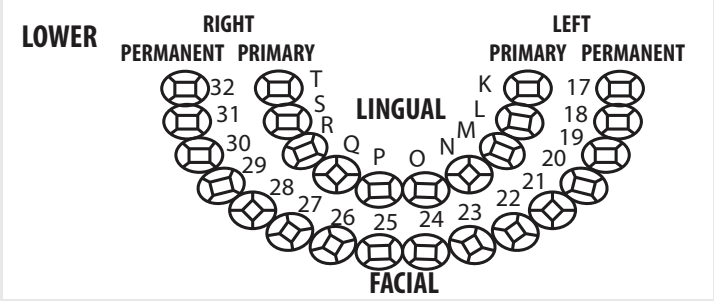
Date patient first experience symptom(s) (DD/MM/YYYY)

Chief complaint and main symptom(s)

☐ Routine dental care ☐ Oral & maxillofacial surgery

Specify the recommended investigations, and/or procedures using the tooth number as shown the teeth map.





Please provide a breakdown of the incurred expenses

a) Consultation/Examination	$
b) X-rays	$
c) Scaling & Polishing	$
d) Filling	$
e) Extraction -Routine/Difficult extraction	$
-Surgical extraction of wisdom tooth	$

f) Medication	$
g) Pulp/Root Canal treatment	$
h) Periodontal Treatment	$
i) Crowning	$
j) Others (Please specify)	$
Total	$

G. Please complete if you are claiming for pre/post natal expenses (if applicable)

Is the pregnancy related to a natural conception? ☐ Yes ☐ No

H. Other Information

Have you claimed or do you intend to claim from any insurer,other employer or any parties for reimbursement of your medical bills?

☐ Yes ☐ No

If 'yes',please state the party that you are claiming from and submit a copy of the settlement letter or payment voucher from the other party?

Note: it is important that you inform us if you are claiming from another insurer, other employer or any other parties for the same bill(s).You can only be reimbursed once for the amount that you have incurred regardless of the number of medical insurance policies you may have. We reserve that right to recover if there is any excess amount paid to you.

I. Payment Details

1. Benefits should be made payable to

☐ Policyholder/Employer ☐ Claimant/Employee ☐ Third Party (For International Exclusive Policy only)

2. Payment is to be made by

☐ Cheque ☐ Direct Credit (For International Exclusive Policy only)

☐ Overseas Telegraphic Transfer (For International Exclusive Policy)

Name of Bank Name of Account Holder

Bank Code Branch Code Account Number

For overseas telegraphic transfer, please provide these additional information

Bank Address

IBAN/SWIFT Code

J. DECLARATION, AUTHORIZATION & CUSTOMER'S DATA PRIVACY CONSENT

[Declaration] I/We confirm that I am/We are the claimant and/or the Policyholder and I/We declare that all the particulars given above are to the best of my/our knowledge true and correct.

[Authorization] I / We hereby consent to and authorize the medical practitioner involved in the claimant's care to discuss and disclose treatment details 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.

[Customer's Data Privacy Consent] In connection with my/our and/or the claimant's claims, I/We give consent for AXA Insurance Pte 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 and/or the claimant, 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 Policyholder when claiming under a Group Policy) for the purpose of enabling AXA and their respective representatives or agents to provide me/us and/or the claimant (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/or managing my/our and/or the claimant's claims or the Policyholder 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").

Signature of Claimant / Employee
(Parent's or Guardian's signature if patient is a minor)

Signature of Patient
(Parent's or Guardian's signature if patient is a minor)

Date (DD/MM/YYYY)

Date (DD/MM/YYYY)

K. TRACK YOUR CLAIM STATUS

Should you have any query on your claim status,please contact us at the following

www.axa.com.sg (File a Claim)
1800 880 4888
(65) 6322 2555
customer.care.health@axa.com.sg (Smart Care Policy)
ops@ipa.sg (International Exclusive Policy)

AXA Insurance is committed to making your claim submission simple and easy.

Thank you for insuring with AXA Insurance, we are proud to serve you.