AXA Life Insurance Singapore Pte Ltd
AXA Health Customer Care Centre
123 Penang Road
#06-13 Regency House
Singapore 238465
Tel: 65-6308 9525
Fax: 65-6235 0739

redefining / insurance

Global Care Health Plan

Pre-Authorization Hospitalization Form

Part I - To be completed by the Insured / Policyholder

Important note:

1. Please note that if your claim form is not fully completed, your claim processing will be delayed.
2. Please complete this form in full in order to assure an accurate processing. All fields are compulsory. We will not be able to process incomplete forms.
3. Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, with intent to mislead, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

1. Details of Insured

Full name of Policyholder	Contact number	NRIC/ Passport number

Full name of Insured	Policy number	Plan

Email address	Date of birth	Gender
	DD/MM/YYYY	

Mailing address

2. Declaration and authorisation

I hereby declare:

(a) that I authorize the Physician, Hospital / Clinic or any other medical institution to give the information and / or medical record, according to the diagnosis and / or medication treatment which given to me or my family which being as the Insured, and

(b) that I authorize AXA Life Insurance Singapore Pte Ltd and its designated third party administrators; to gather further information / medical records from the Hospital and or other parties related to the diagnosis and or health services provided to me or eligible members of my family which may be required to process the claim in accordance with existing policy and term conditions.

(c) that all information on this medical claim form was written truthfully and I hereby agree that this Letter of Authority to be used promptly.

(d) that copy of this Declaration is as valid and has power in accordance with the original document.

(e) that I authorize my Financial Advisor / Agent to discuss medical conditions as necessary with my insurer or its authorized agent on my behalf. Please tick the box ☐ if you do not authorize your Financial Advisor / Agent to discuss medical conditions with your insurer or its authorized agent on your behalf.

(f) that I am the patient/ the patient's parent or guardian if the patient is under 18 years of age.

Signature of Insured/ Policyholder	Date	Relationship to Insured
	DD/MM/YYYY	

Name of Insured/ Policyholder	NRIC/ Passport number	Date of birth
		DD/MM/YYYY

Name of Financial Advisor/ Agent	Date	Contact number
	DD/MM/YYYY	

Please fully complete all sections in order for us to process your claim.

3. Medical Details

(a) Have you or the Insured received any previous consultation/ treatment/ hospitalization for this condition and /or associated conditions or symptoms, in hospital or other facilities?

Date	Disease/ Disorder (Details of treatment)	Doctor/ Hospital	Contact details
DD/MM/YYYY			
DD/MM/YYYY			
DD/MM/YYYY			
DD/MM/YYYY			
DD/MM/YYYY			

(b) Please provide details of your or the Insured's doctor/ company doctor / other doctors below.

Date	Name of doctor	Hospital/ Clinic	Contact details
DD/MM/YYYY			
DD/MM/YYYY			
DD/MM/YYYY			
DD/MM/YYYY			
DD/MM/YYYY			

(c) Please provide details of the doctor who referred you/ the insured for this treatment.

Date	Name of doctor	Hospital/ Clinic	Contact details
DD/MM/YYYY			
DD/MM/YYYY			

4. Accident Claims

Is the treatment related to accident? ☐ Yes ☐ No

☐ Road traffic accident ☐ Work related accident ☐ Others: _____ (*please tick appropriately*)

Please provide chronology of events

5. Claiming Information

(a) Is the treatment covered by another insurance policy?
☐ Yes ☐ No
If yes, please provide details.

(b) Is the treatment covered by Workman's Compensation policy?
☐ Yes ☐ No
If yes, please provide details.

6. Guidelines for document submission

Please tick against the documents you have submitted together with this claim form. We will notify you or your Financial Advisor if we need to obtain extra information from you or from other parties to assess your claim. As the time required for obtaining the information varies, the processing time of your claim will likely take longer time.

☐ 1. Claims form which is to be completed fully (original)

☐ 2. Cost details (original/ certified copy/ copy)

☐ 3. Result of the diagnostic test (Laboratory result, X-Ray, etc- original/ certified copy/ copy)

☐ 4. Original payment receipt

☐ 5. Prescription (original/ certified copy/ copy)

☐ 6. Tax invoice or original receipt (for overseas treatment)

7. Policyholder's bank account details

Payment will be made in the currency defined in the plan unless we agreed otherwise in writing and bank charges incurred will be borne by the Policyholder.

Amount claimed	Name of bank account holder	Bank account number

Bank name	Bank SWIFT code	Bank address

*If you have any questions regarding this form or any other aspects of the coverage, please contact our **AXA Health Customer Care Centre** at **65-6308 9525** quoting your policy / membership numbers. Claims must be submitted along with all supporting documents within **90** days from date of service.*
*Send this claim form together with all supporting documents to **AXA Health Customer Care Centre** at **123 Penang Road, #06-13 Regency House, Singapore 238465***

Please fully complete all sections in order for us to process your claim.

Part II - To be completed by the attending doctor at the Insured or Policyholder's expense

Important note:

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, with intent to mislead, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

1. Patient's details

Full name of patient	NRIC/ Passport number	Date of birth	Gender
		DD/MM/YYYY	

2. Patient's medical details

(a) Medical condition/ Diagnosis

(b) ICD code

(c) Surgical code

(d) Symptoms presented

(e) Date the patient first consulted you for this condition — DD/MM/YYYY

(f) Date of treatment — DD/MM/YYYY

(g) If there are symptoms presented, please advise:

(i) how long has the condition existed prior to consulting you?

(ii) when the symptoms first started? — DD/MM/YYYY

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

(i) In your expert opinion and per history provided to you by the patient, given the aetiology of the condition, please state the estimated duration of such condition would be in existence for this patient.

(j) Treatment plan

(k) Admitting hospital

(l) Estimated length of treatment (in days)

(m) Estimated hospital costs

Room type	
Room per night	
Total room & all hospital costs estimate	

(n) Estimated cost for surgeon and anaesthetist

i. Daily visit estimate	
ii. Surgery estimate	
Surgeon/Treating doctor's total estimate (i+ii)	
Anaesthetist's estimate	

Please fully complete all sections in order for us to process your claim.

(o) Was the patient referred to you by another doctor? ☐ Yes ☐ No
If yes, please provide the name of referring doctor & contact details.

(p) Does the patient suffer from other medical condition(s)? ☐ Yes ☐ No
If yes, please state the medical condition(s) and the date of diagnosis.

(q) Are these medical conditions associated to the current condition? Kindly explain the association.

(r) Investigation (describe necessary investigations requested/ required to define the diagnosis)

(s) Further treatment plan

(t) Is the condition/ treatment/ surgery related to any of these? ☐ Yes ☐ No
If yes, please provide details.
☐ Pregnancy or childbirth
☐ Congenital anomaly
☐ Abortion or miscarriage
☐ Genetic or chromosomal disorder
☐ Infertility or sub-fertility condition
☐ Metal or psychiatric condition
☐ Sexually transmitted disease
☐ Cosmetic reason

(u) Is the treatment related to accident? ☐ Yes ☐ No
If yes, please provide details.
☐ Road traffic accident ☐ Work related accident ☐ Others: _____ (*please tick appropriately*)
Please provide chronology of events

3. Medical practitioner's declaration

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his/her condition. I declare and agree to make the declaration on this claim form.

Signature of physician

Date
DD/MM/YYYY

Contact number

Name of physician

Qualification

Specialty

Hospital/ clinic stamp

Mailing address

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Please fully complete all sections in order for us to process your claim.