AIA SINGAPORE
CITIBANK CREDIT INSURE GOLD
HOSPITALISATION INCOME CLAIM FORM

CLAIM PROCEDURES

FOR HOSPITALISATION INCOME BENEFIT CLAIM

Please furnish the following documents within 90 days from date of discharge :-

a) Duly completed Claimant's Statement (to be completed by Insured Person)

b) Duly completed Physician's Statement by the Attending Physician / Surgeon. The cost of such report will be borne by the Insured Person

c) Copy of the Hospital Discharge Summary (if any)

d) Copy of Laboratory Report (if any)

e) Copy of Billing Statement for all eligible credit facilities prior to first day of Hospital Confinement

f) Any other documents required will be based on the case itself

g) For details of Coverage, Exclusions and any other terms and conditions, please refer to Credit Insure Gold Certificate

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Section 1 - Claimant's Statement

Part A : To be completed by Insured Person / Claimant / Next-Of-Kin			
Name of Insured Person		NRIC / Passport No.	Date of Birth (DD/MM/YY)
Gender ☐ Female ☐ Male	Contact No.	Personal Email Address	
Address of Insured Person for Correspondence			

Part C: Details of Admission (For Hospitalisation Income Benefit)		
Nature of Illness / Final Diagnosis	Symptoms Experienced	Date of Symptoms First Started (DD/MM/YY)
Date First Treated (DD/MM/YY)	Admission Date (DD/MM/YY)	Discharge Date (DD/MM/YY)
Hospital Name	Final Diagnosis after discharge	Nature of Treatment / Operation Done

Part C : Declaration and Authorisation

1) I/We acknowledge and accept that the furnishing of this form, or of any other forms supplemental thereto, by AIA Singapore Private Limited ("AIA Singapore") is neither an admission that there was any insurance in force on the life in questions, nor an admission of liability nor a waiver of any of its rights or defences.

2) I/We
   a) hereby declare that I/we are duly authorised to make this claim and all statements and responses whether on this form or otherwise together with any required questionnaire, amendments, materials and supporting documents submitted in connections with the claim and the Policy ("Information");
   b) declare that all information is complete, true and correct and that no information or materials have been withheld and that AIA Singapore will rely and act on the Information accordingly. Otherwise, AIA Singapore shall be at liberty to deny liability or recover amounts paid whether wholly or partially;
   c) acknowledge and accept that AIA Singapore shall be a liberty to deny liability or recover amount paid, whether wholly or partially, if any of the information is incomplete, untrue or incorrect in any respect of if the Policy does not provide cover on which such claim is made; and
   d) acknowledge and accept that AIA Singapore expressly reserves its rights or obtain further information as it deems necessary.

3) I/We hereby authorize, agree and consent to AIA Singapore to request from any hospital, physician, person or organization, all information with respect to any illness, injury, medical history, and copies of all hospital or medical records concerning myself at any time and authorize the prior mentioned organizations to disclose all such information to AIA Singapore.

4) I/We consent to AIA Singapore, its associated persons/organisations, third party service providers and representatives, whether within or outside Singapore (collectively "**AIA Persons**") to collect, use, disclose, store, retain and/or process (collectively, "**Use**") all personal data and information ("**Personal Data**") provided to AIA Persons or that they possess about me/us, in the manner and for the purposes described in the AIA Personal Data Policy ("**PD Policy**") which is available on AIA Singapore's website.

5) I/We agree to accept the provisions in the PD Policy as amended from time to time. Where Personal Data of another person is disclosed by me/us, I/we confirm that I/we have obtained the consent of the individual concerned, except to the extent such consent is not required under relevant laws to collect, use and/or disclose such Personal Data. I/We waive (on my/our own behalf and on behalf of each such other person) any right to claim against any of the AIA Persons for any Use in the nature of or for the purposes described above or in the PD Policy. I/We will indemnify AIA Persons for all losses and damages if I/we breach these provisions.

6) This consent shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not our Application/form is accepted by AIA Singapore. A photocopy of this consent shall be valid and effective as the original.

Signature of Insured Person

Date (DD/MM/YY)

Part D : To be completed by Witness	
Name of Witness	NRIC / Passport No.
Signature	Date

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Section 2 : Physician's Statement – For Hospitalisation Income Benefit

To be completed by Attending Physician (The medical report fee, if any, will be borne by the Claimant)

1) Name of Patient | NRIC / Passport No.

2) Final Diagnosis of illness or extent of injury | ICD Code | ICD Code | ICD Code

3) What is the cause of illness / injury?

4) Please specify the approximate date of discovery of the illness or injury

5) How long has the illness / injury been existing prior to consulting you?

6) Did the patient have any symptoms prior to consulting you?
❒ Yes ❒ No - If "Yes", please indicate the nature of Symptoms and date Symptoms first started:

7) When did the patient first consult you for this condition?

8) Nature and Date of Treatment rendered

9) Has the patient ever had the same or similar condition / symptom? ❒ Yes ❒ No ❒ Not to my knowledge
If "Yes", please indicate when and describe

10) Has the patient had any prior treatment for this condition? ❒ Yes ❒ No ❒ Not to my knowledge
If "Yes", please state the following :-

Name of Doctor	First Consultation Date	Name of Clinic	Address

11) Admission Period

12) Name of Hospital

13) Date of surgical procedures or treatment rendered

14) Vaccine Adverse Event reported to HSA? ❒ Yes ❒ No
If "No", please indicate why

15) Describe the surgical procedures or treatment rendered. If no surgery was performed, please state treatment / medication given.

Operation Code | Operation Table

16) Were the above surgical procedures approached through the same incision / orifice? ❒ Yes ❒ No

17) Was the surgery performed for cosmetic purposes?
❒ Yes ❒ No

18) Is the condition / treatment related to :

	Yes	If "Yes", please elaborate	No
a) Congenital Anomaly / Genetic / Chromosomal Disorder	a)		
b) Psychological / Mental / Emotional Disorder	b)		
c) Dental / Gum Treatment / Oral Mucosal	c)		
d) Pregnancy / Childbirth / Infertility / Sub-fertility Condition	d)		
e) Self-inflicted Injury / Drug Addition / Alcoholism	e)		

19) Is the patient still under your care for this condition? ❒ Yes ❒ No - If "No" please give date service was terminated and furnished name and address of doctor if the patient has been referred to another doctor for follow-up.

Signature of Physician / Surgeon

Date (DD/MM/YY)

Name / Designation

Name and Address of Clinic / Hospital & Stamp