**AIA Bhd.** (790895-D)
Corporate Solutions Division
Menara AIA, 99 Jalan Ampang, 50450 Kuala Lumpur
P. O. Box 10140, 50704 Kuala Lumpur
T : 03-2056 1111

# Corporate Solutions - Hospital & Surgical Claim (For Worksite Product) January 2021

**CLAIM NO.** For Office Use Only

| IMPORTANT NOTE | CHECKLIST ON SUBMISSION OF CLAIM DOCUMENTS | | |
|---|---|---|---|
| | TYPE OF CLAIM | | |
| 1. One form for **ONE** admission and related to Pre & Post visit.<br>2. Claim for hospitalisation & surgical expenses must be submitted within 90 days from the date of discharge or consultation.<br>3. For Overseas Treatment, the original Detailed Admission Bill showing details of each charges must be provided. English translation must be provided if the bill is in foreign language.<br>4. AIA Bhd. will keep the claim documents unless you requested for the documents to be returned to you within 60 days from the decision of the claim.<br>5. A copy of Identity Card (NRIC) or Passport must be provided.<br>6. Field marked with (*) is compulsory. | ☐ Hospitalisation / Daycare Treatment<br>*1. Copy of Identity Card (NRIC) or Passport<br>*2. Original Official Receipt (Deposit & Final Payment)<br>3. Detailed Itemised Bill<br>4. Medical Report / Section II of this form<br>• For Government Hospital bill above RM1,000.<br>• For Private Hospital bill above RM500.<br>5. Copy of Investigation Report [Lab / Imaging / Procedure Performed (if any)]<br>6. Physiotherapy Details - visit date & amount for each treatment session done (Advance payment NOT accepted) | ☐ Pre & Post Hospitalisation<br>*1. Copy of Identity Card (NRIC) or Passport<br>*2. Original Official Receipt (Deposit & Final Payment)<br>3. Detailed Itemised Bill<br>4. Copy of Investigation Report [Lab / Imaging / Procedure Performed (if any)]<br>5. Physiotherapy Details - visit date & amount for each treatment session done (Advance payment NOT accepted) | ☐ Accidental Claim<br>*1. Copy of Identity Card (NRIC) or Passport<br>*2. Original Official Receipt (Deposit & Final Payment)<br>3. Detailed Itemised Bill<br>4. Medical Report / Section II of this form<br>• For Government Hospital bill above RM1,000.<br>• For Private Hospital bill above RM500.<br>5. Copy of Investigation Report [Lab / Imaging / Procedure Performed (if any)]<br>6. Copy of Police Report (if any) |

Assessment of the claim may be delayed if documents are incomplete.

**SECTION I -** To be completed by the Insured (IN BLOCK LETTERS)

## A. INFORMATION ON THE POLICY AND INSURED PERSON

Policy No.

*Product Name

*Name of Policy Owner

*Name of Insured Person

*Insured Person NRIC No. / Passport No.

*Mobile No. - This number will be used for your claim status notification.

*Email Address

## B. FOR ACCIDENTAL CAUSE ONLY

*Date of Accident (d d - m m - y y y y)

*Time : ☐ am ☐ pm

*Details of Accident (brief explanation of the cause):

## C. DETAILS OF OTHER INSURANCE POLICIES, SOCSO, WORKMEN'S COMPENSATION AND OTHERS

Policy Type ☐ Hospital & Surgical ☐ Other(s) _____ (e.g. SOCSO) | Policy No.

Insurance Company | ☐ Not insured under any program, benefits, schemes or insurance.

## D. CLAIM AMOUNT

*RM .

## E. *E-PAYMENT REGISTRATION FOR OWNER (MANDATORY REQUIREMENT)

☐ Change of account number for this claim and future transactions.

☐ Use the existing payment details in AIA Bhd. record.

Notes:
(a) AIA shall not be responsible for losses as a result of inaccurate account details provided.
(b) Only employee bank account details allowed.

Bank Name

Bank Account Holder Name

Bank Account No.

## F. DECLARATION AND AUTHORISATION

1. I/We confirm that the information given are true and accurate.
2. I/We understand that for Overseas Treatment, I/we must include Original Detailed Admission Bill showing details of each charges. The bill must have an English translation if it is in a foreign language.
3. I/We understand AIA Bhd. will keep my/our claim documents unless if I/we request for the documents to be returned to me within 60 days from the decision of claim.
4. I/We understand that AIA Bhd.'s acceptance of this Hospital & Surgical Claim Form is not an admission of AIA Bhd.'s liability of my/our claim.
5. I/We authorise any institution or individual that has any records or knowledge of my/our health and medical history to disclose such information to AIA Bhd. or its representative.
6. I/We understand and agree that any personal information collected or held by AIA Bhd. (whether through this Hospital & Surgical Claim form or otherwise obtained) may be used and disclosed by AIA Bhd. to individuals/institutions related to and associated with AIA Bhd. or any selected third party within or outside Malaysia such as reinsurers, claims investigation companies and industry associations to process this Hospital & Surgical Claim form. The information may also be used to provide service for this and other financial products and to communicate with me/us. I/We understand that I/we have a right to get access to and request for correction of any personal information held by AIA Bhd. Such requests can be made at any AIA Bhd. Customer Centres.

Signature of Insured Person _____ Date _____

## SECTION II - To be completed by the Attending Doctor (IN BLOCK LETTERS) - Please answer all questions

**MRN No.:**

1. a) Patient Name
   b) NRIC
   c) Age
   d) Gender ☐ Male ☐ Female
2. Admission Date and Time: d d - m m - y y y y  : (hrs)
3. Discharge Date: d d - m m - y y y y
4. Date of MC: d d - m m - y y y y to d d - m m - y y y y
   No. of MC days: ___
5. a) Symptoms / Conditions requiring admission:
   b) How long is patient aware of the condition:
   c) Patient's BP / Temp / Pulse:
   d) Date symptoms first appeared: d d - m m - y y y y
   e) Date first consulted: d d - m m - y y y y
6. a) Any previous consultation / treatment / hospitalisation for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities?
   ☐ Yes ☐ No
   b) Was this patient referred? If Yes, please provide details:
   c) If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed:

| Date | Disease / Disorder | Details of Treatment / Hospitalisation | Doctor / Hospital / Clinic |
|---|---|---|---|
| | | | |

   d) Can the condition be managed under the Outpatient basis: ☐ Yes ☐ No
   If No, please provide reasons of admission: _____
7. Any other medical / surgical conditions present? ☐ No ☐ Yes, details below:
   a) _____ since d d - m m - y y y y
   b) _____ since d d - m m - y y y y
8. a) Final Diagnosis / ICD Coding
   i)
   ii)
   iii)
   b) Cause and pathology of the diagnosis:
9. Treatment given / Investigation done (Please supply copy of all investigation results):
10. a) Surgical procedures performed:
    MMA code / PHFSR code:
    b) Date of surgery / procedure: d d - m m - y y y y
11. Is the illness / condition related to: (please tick ✓ if YES)
    a) ☐ Childbirth / Infertility / Caesarean Section / Miscarriage or Any Complications Arising Therefrom
    b) ☐ Congenital / Hereditary Disease
    c) ☐ Influence of Drugs / Alcohol
    d) ☐ Nervous / Mental / Emotional / Sleeping Disorder
    e) ☐ Cosmetic Reason / Dental Care / Refractive Errors Correction
    f) ☐ AIDS / STD / VD / HIV
    g) ☐ Self-inflicted Injuries / Violation of Laws / Strike / Riots
    h) ☐ None of the above
12. Was the patient pregnant at the time of hospitalisation? (For Females Only) ☐ No ☐ Yes, _____ months
13. I hereby certify that I have personally examined and treated the Patient for his / her injuries / illness described above and that the facts as stated above represent my medical opinion of his / her condition.

Name & Signature of Attending Doctor _____ Doctor / Hospital Stamp _____ Date _____