



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

|                                      |
|--------------------------------------|
| <b>CLAIM NO.</b> For Office Use Only |
|--------------------------------------|

| IMPORTANT NOTE   | CHECKLIST ON SUBMISSION OF CLAIM DOCUMENTS  |  |  |
|--|---|--|--|
|  | TYPE OF CLAIM   |  |  |
| <p>1. One form for <b>ONE</b> admission and related to Pre &amp; Post visit.</p> <p>2. Claim for hospitalisation &amp; surgical expenses must be submitted within 90 days from the date of discharge or consultation.</p> <p>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.</p> <p>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.</p> <p>5. A copy of Identity Card (NRIC) or Passport must be provided.</p> <p>6. Field marked with (*) is compulsory.</p> | <input type="checkbox"/> Hospitalisation / Daycare Treatment<br><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 <ul style="list-style-type: none"> <li>For Government Hospital bill above RM1,000.</li> <li>For Private Hospital bill above RM500.</li> </ul> 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) | <input type="checkbox"/> Pre & Post Hospitalisation<br><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) | <input type="checkbox"/> Accidental Claim<br><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 <ul style="list-style-type: none"> <li>For Government Hospital bill above RM1,000.</li> <li>For Private Hospital bill above RM500.</li> </ul> 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.   |  |  |
|  | <b>SECTION I - To be completed by the Insured (IN BLOCK LETTERS)</b>  |  |  |

**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<br><input type="text"/> / <input type="text"/> / <input type="text"/><br><input type="text"/> / <input type="text"/> / <input type="text"/> | *Time<br><input type="text"/> : <input type="text"/> <input type="checkbox"/> am <input type="checkbox"/> pm | *Details of Accident (brief explanation of the cause):<br><input type="text"/> |
|---|--|--|

**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)**

|   |                          |
|---|--------------------------|
| <input type="checkbox"/> Change of account number for this claim and future transactions.<br><input type="checkbox"/> Use the existing payment details in AIA Bhd. record.<br><br><b>Notes:</b><br>(a) AIA shall not be responsible for losses as a result of inaccurate account details provided.<br>(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<br><input type="checkbox"/> Male <input type="checkbox"/> Female |
|--------------------|---------|--------|--|

|  |   |
|--|---|
| 2. Admission Date and Time<br>[d][d] - [m][m] - [y][y][y][y] [ ] : [ ] (hrs) | 3. Discharge Date<br>[d][d] - [m][m] - [y][y][y][y] |
|--|---|

|   |                               |
|---|-------------------------------|
| 4. Date of MC<br>[d][d] - [m][m] - [y][y][y][y] to [d][d] - [m][m] - [y][y][y][y] | No. of MC days<br>[ ] [ ] [ ] |
|---|-------------------------------|

|  |  |
|--|--|
| 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:<br>[d][d] - [m][m] - [y][y][y][y] | e) Date first consulted:<br>[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?<br><input type="checkbox"/> Yes <input type="checkbox"/> 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:<br><u>Date</u> <u>Disease / Disorder</u> <u>Details of Treatment / Hospitalisation</u> <u>Doctor / Hospital / Clinic</u> |
|--|

|  |
|--|
| d) Can the condition be managed under the Outpatient basis: <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|

|   |
|---|
| If No, please provide reasons of admission: _____ |
|---|

|  |
|--|
| 7. Any other medical / surgical conditions present? <input type="checkbox"/> No <input type="checkbox"/> 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 | b) Cause and pathology of the diagnosis: |
|------------------------------------|--|

|      |  |
|------|--|
| i)   |  |
| ii)  |  |
| iii) |  |

|  |
|--|
| 9. Treatment given / Investigation done (Please supply copy of all investigation results): |
|--|

|   |   |
|---|---|
| 10. a) Surgical procedures performed:<br><br>MMA code / PHFSR code: | b) Date of surgery / procedure:<br>[d][d] - [m][m] - [y][y][y][y] |
|---|---|

|   |
|---|
| 11. Is the illness / condition related to: (please tick ✓ if YES) |
|---|

|   |  |
|---|--|
| a) <input type="checkbox"/> Childbirth / Infertility / Caesarean Section / Miscarriage or Any Complications Arising Therefrom | e) <input type="checkbox"/> Cosmetic Reason / Dental Care / Refractive Errors Correction |
| b) <input type="checkbox"/> Congenital / Hereditary Disease   | f) <input type="checkbox"/> AIDS / STD / VD / HIV  |
| c) <input type="checkbox"/> Influence of Drugs / Alcohol  | g) <input type="checkbox"/> Self-inflicted Injuries / Violation of Laws / Strike / Riots |
| d) <input type="checkbox"/> Nervous / Mental / Emotional / Sleeping Disorder  | h) <input type="checkbox"/> None of the above  |

|  |
|--|
| 12. Was the patient pregnant at the time of hospitalisation? (For Females Only)    No <input type="checkbox"/> 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