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

CLAIM NO. For Office Use Only

Corporate Solutions - Inpatient Claim

IMPORTANT NOTE	CHECKLIST ON SUBMISSION OF CLAIM DOCUMENTS		
	TYPE OF CLAIM		
1. One form for **ONE** admission & related Pre & Post visit. 2. Claim for hospitalisation & surgical expenses must be submitted within 90 days from the date of discharge or consultation. 3. I understand that for Overseas Treatment, I must include Original Detailed Admission Bill showing details of each charges. The bill must have the English translation if it is in a foreign language. 4. I understand AIA Bhd. will keep my claim documents unless if I request for the documents to be returned to me within 60 days from the decision of claim.	☐ Hospitalisation / Daycare Treatment 1. Original Receipt (Deposit & Final Payment) 2. Detailed Itemised Bill 3. Medical Report / Section II of this form • For Government Hospital bill above RM1,000. • For Private Hospital bill above RM500. 4. Copy of Investigation Report [Lab / Imaging / Procedure Done (if any)] 5. Physiotherapy Details - visit date & amount for each treatment session done (Advance payment NOT accepted) *GHS1*	☐ Pre & Post Hospitalisation 1. Original Receipt (Deposit & Final Payment) 2. Detailed Itemised Bill 3. Copy of Investigation Report [Lab / Imaging / Procedure Done (if any)] 4. Physiotherapy Details - visit date & amount for each treatment session done (Advance payment NOT accepted) *POST*	☐ Accidental Claim 1. Original Receipt (Deposit & Final Payment) 2. Detailed Itemised Bill 3. Medical Report / Section II of this form • For Government Hospital bill above RM1,000. • For Private Hospital bill above RM500. 4. Copy of Investigation Report [Lab / Imaging / Procedure Done (if any)] 5. Copy of Police Report (if any) *GHS1*

Assessment of the claim may be delayed if the checklist are not completed.

SECTION I - To be completed by the Employee / Patient (IN BLOCK LETTERS)
Remarks: All fields marked with (*) are compulsory.

A. EMPLOYEE INFORMATION

*Name of Employee (as in NRIC)

*Employee NRIC No. / Passport No.

Policy No.

Plan

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

Occupation

Date of Employment (d d - m m - y y y y)

Date of Group Insurance Participation (d d - m m - y y y y)

Gender ☐ Male ☐ Female

*Email Address

*Name of Company / Employer

B. PATIENT INFORMATION

*Name of Patient ☐ Same as above

*Membership No. (as in Member ID Card)

Gender ☐ Male ☐ Female

Relationship to Employee ☐ Spouse ☐ Child

C. FOR ACCIDENTAL CAUSE ONLY

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

*Time : ☐ am ☐ pm

*Details of Accident:

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

Policy Type

Policy No.

Insurance Company

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

E. CLAIM AMOUNT

*RM .

F. E-PAYMENT REGISTRATION (If no selection is made, the payment will be made as per our record)

☐ Use the payment details that have been recorded by AIA Bhd.

☐ New enrollment / change of account number for this claim and future transactions.

(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.

G. INFORMATION ON GOODS AND SERVICE TAX ACT 2014

Are you GST registered? ☐ Yes ☐ No

If "Yes", please provide us your GST Registration Number.

Registration Date (d d - m m - y y y y)

Note:
If question above are unanswered, you will be treated as non-GST Registered or, AIA Bhd. will follow your existing records with the company (if any).

AIA Bhd. shall rely on the above information provided by you for tax credit purposes provided under the GST Act. AIA Bhd. shall not be liable for any liability or any fine, charge or penalty as a result of relying on your incorrect advice. Should action be taken against AIA Bhd. and / or penalties be imposed on AIA Bhd. by any tax authority for relying on the same, AIA Bhd. reserves its right to be indemnified by you to the fullest extent permitted by law and any GST liability arising from your incorrect advice shall be payable by you. This information shall also be used in all other claims made with AIA Bhd.

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H. DECLARATION AND AUTHORISATION

I/We confirm that the answers given are true and accurate.

I/We understand that AIA Bhd.'s acceptance of this form is not an admission of AIA Bhd.'s liability of my/our claim.

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.

I/We understand and agree that any personal information collected or held by AIA Bhd. (whether through this application 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 application. 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.

	Employer's Signature, Stamp & Address
Signature of Employee _____ 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
_____	_____	_____

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NO. TUNTUTAN Untuk Kegunaan Pejabat Sahaja

Corporate Solutions - Tuntutan Hospital & Pembedahan

NOTA PENTING	SENARAI SEMAK BAGI PENYERAHAN DOKUMEN-DOKUMEN TUNTUTAN		
	JENIS TUNTUTAN		
1. Setiap borang tuntutan adalah untuk **SATU** kemasukan ke hospital & lawatan sebelum & selepas yang berkaitan dengannya. 2. Tuntutan hospitalisasi & perbelanjaan pembedahan mesti dihantar dalam masa 90 hari daripada tarikh keluar hospital atau tarikh rundingan. 3. Saya memahami bahawa untuk Rawatan Di Luar Negara, Butiran Bil Asal yang terperinci menyenaraikan butir-butir setiap caj dan terjemahan bahasa asing ke Bahasa Inggeris perlu disertakan. 4. Saya memahami bahawa AIA Bhd. akan menyimpan dokumen tuntutan saya melainkan jika saya memohon untuk dokumen tersebut dikembalikan kepada saya dalam masa 60 hari dari tarikh keputusan tuntutan.	☐ Kemasukan ke Hospital / Jagaan Harian 1. Resit Asal (Deposit & Bayaran Akhir) 2. Butiran Bil Terperinci 3. Laporan Perubatan / Section II di dalam borang ini • Sekiranya bil melebihi RM1,000 untuk Hospital Kerajaan. • Sekiranya bil melebihi RM500 untuk Hospital Swasta. 4. Salinan Laporan Penyiasatan [Makmal / Pengimejan / Prosedur Dilakukan (jika ada)] 5. Maklumat Fisioterapi - tarikh rawatan dan jumlah bagi setiap sesi rawatan (Resit bayaran pendahuluan TIDAK akan diterima) *GHS1*	☐ Pra & Selepas Rawatan Hospital 1. Resit Asal (Deposit & Bayaran Akhir) 2. Butiran Bil Terperinci 3. Salinan Laporan Penyiasatan [Makmal / Pengimejan / Prosedur Dilakukan (jika ada)] 4. Maklumat Fisioterapi - tarikh rawatan dan jumlah bagi setiap sesi rawatan (Resit bayaran pendahuluan TIDAK akan diterima) *POST*	☐ Tuntutan Kemalangan 1. Resit Asal (Deposit & Bayaran Akhir) 2. Butiran Bil Terperinci 3. Laporan Perubatan / Section II di dalam borang ini • Sekiranya bil melebihi RM1,000 untuk Hospital Kerajaan. • Sekiranya bil melebihi RM500 untuk Hospital Swasta. 4. Salinan Laporan Penyiasatan [Makmal / Pengimejan / Prosedur Dilakukan (jika ada)] 5. Salinan Laporan Polis (jika ada) *GHS1*

Penilaian ke atas tuntutan ini akan mengalami kelewatan sekiranya senarai semak di dalam borang ini tidak lengkap.

SEKSYEN I - Untuk diisi oleh Pekerja / Pesakit (DALAM HURUF BESAR)
Kenyataan: Semua ruangan bertanda (*) adalah wajib diisi.

A. MAKLUMAT PEKERJA

*Nama Pekerja (seperti di dalam KP)

*No. KP Pekerja / No. Pasport | No. Polisi | Pelan

*No. Tel. Bimbit (Nombor telefon ini akan digunakan untuk makluman tuntutan anda.) | Pekerjaan

Tarikh Mula Bekerja (hh - bb - tttt) | Tarikh menyertai Skim Insurans Berkumpulan (hh - bb - tttt) | Jantina ☐ Lelaki ☐ Perempuan

*Alamat Emel

*Nama Syarikat / Majikan

B. MAKLUMAT PESAKIT

*Nama Pesakit ☐ Sama seperti di atas

*No. Keahlian (seperti di dalam Kad Keahlian) | Jantina ☐ Lelaki ☐ Perempuan | Hubungan dengan Pekerja ☐ Suami / Isteri ☐ Anak

C. UNTUK KES KEMALANGAN SAHAJA

*Tarikh Kemalangan (hh - bb - tttt) | *Masa (:) ☐ am ☐ pm | *Butir-butir Kemalangan:

D. BUTIR-BUTIR INSURANS LAIN, PERKESO, INSURANS PAMPASAN PEKERJA DAN LAIN-LAIN

Jenis Polisi | No. Polisi

Syarikat Insurans | ☐ Tidak dilindungi oleh mana-mana program, faedah ataupun skim insurans lain.

E. AMAUN YANG DITUNTUT

*RM .

F. PENDAFTARAN E-PEMBAYARAN (Jika tiada pilihan dibuat, pembayaran akan dibuat mengikut rekod kami yang sedia ada)

☐ Guna maklumat yang sedia ada di dalam rekod AIA Bhd.

☐ Untuk pendaftaran baru atau perubahan nombor akaun bagi transaksi pembayaran masa hadapan.

(a) AIA tidak akan bertanggungjawab terhadap sebarang kerugian sekiranya maklumat akaun yang diberikan tidak tepat.
(b) Hanya maklumat akaun bank pekerja diterima.

Nama Bank

Nama Pemegang Akaun Bank

No. Akaun Bank

G. MAKLUMAT AKTA CUKAI BARANGAN DAN PERKHIDMATAN 2014

Adakah anda berdaftar untuk GST? ☐ Ya ☐ Tidak | Jika "Ya", sila nyatakan Nombor Pendaftaran GST anda. | Tarikh Pendaftaran (hh - bb - tttt)

Nota:
Jika soalan di atas tidak dijawab, anda akan dianggap sebagai bukan GST Berdaftar atau, AIA Bhd. akan mengikuti rekod yang sebelum ini (jika ada).

AIA Bhd. bergantung kepada maklumat yang diberikan oleh anda untuk kredit cukai yang diperuntukkan di bawah Akta GST. AIA Bhd. tidak akan bertanggungjawab terhadap sebarang liabiliti atau apa-apa denda, penalti atau caj jika maklumat yang diberikan oleh anda tidak betul. Sekiranya tindakan dan / atau penalti dikenakan ke atas AIA Bhd. oleh mana-mana pihak berkuasa, AIA Bhd. berhak menuntut kerugian dari anda sehingga tahap yang dibenarkan oleh undang-undang dan sebarang liabiliti GST yang wujud berdasarkan maklumat yang tidak betul. Maklumat di atas akan digunakan untuk semua tuntutan dengan AIA Bhd.

H. PENGAKUAN DAN PEMBERIAN KUASA

Saya/Kami mengesahkan bahawa jawapan yang diberikan adalah benar dan tepat.

Saya/Kami memahami bahawa penerimaan borang oleh AIA Bhd. tidak boleh dianggap sebagai penerimaan liabiliti ke atas tuntutan yang dibuat.

Saya/Kami memberi kuasa kepada mana-mana institusi atau individu yang mempunyai rekod atau maklumat tentang kesihatan dan sejarah perubatan saya/kami untuk mendedahkannya kepada AIA Bhd. atau wakil AIA Bhd.

Saya/Kami memahami dan bersetuju bahawa maklumat peribadi yang dikumpul atau dipegang oleh AIA Bhd. (sama ada melalui pemohonan ini ataupun cara lain) boleh digunakan dan didedahkan kepada individu atau institusi yang berkaitan dengan AIA Bhd. atau mana-mana pihak ketiga di dalam atau di luar Malaysia seperti penanggung insurans semula (reinsurer), syarikat penyiasatan tuntutan dan persatuan industri bagi memproses permohonan ini. Maklumat tersebut juga boleh digunakan untuk memberikan perkhidmatan ke atas permohonan ini dan juga produk kewangan lain. Saya/Kami memahami bahawa saya/kami mempunyai hak untuk mendapatkan dan memohon pembetulan dibuat ke atas mana-mana maklumat persendirian yang disimpan oleh AIA Bhd. Permohonan tersebut boleh dibuat di mana-mana cawangan Pusat Khidmat Pelanggan AIA Bhd.

Tandatangan Pekerja	Tarikh	Tandatangan, Cop Rasmi & Alamat Majikan

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