AIA Bhd. (790895-D)
Corporate Solutions Division
Menara AIA, 99 Jalan Ampang, 50450 Kuala Lumpur
P. O. Box 10140, 50704 Kuala Lumpur
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CLAIM NO. For Office Use only

Member Hospital & Surgical Claim Form (AIA Health Services)

Borang Tuntutan Hospital & Pembedahan Ahli

Type of Claim / ***Jenis Tuntutan***

☐ Hospitalisation / *Kemasukan ke Hospital*
☐ Pre & Post Hospitalisation / *Pra & Selepas Rawatan Hospital*
☐ Nature of Illness/Injury / *Jenis Penyakit/Kecederaan* _____

SECTION I - To be completed by the Employee/Patient (IN BLOCK LETTERS) for submission to AIA for claim processing.
SEKSYEN I - Untuk diisi oleh Pekerja/Pesakit (DALAM HURUF BESAR) & diserahkan kepada AIA untuk tuntutan.
Note: All fields marked with (*) are compulsory. / ***Nota: Semua ruangan bertanda (*) adalah wajib.***

Employee Information / ***Maklumat Pekerja***

*Name of Employee (as in NRIC) / *Nama Pekerja (seperti di dalam KP)*

*Employee NRIC No. / *No. KP Pekerja*

Policy No. / *No. Polisi*

Plan / *Pelan*

*Member ID / *No. Ahli*

Marital Status / *Status Perkahwinan*
☐ Single / *Bujang* ☐ Married / *Berkahwin*

Occupation / *Pekerjaan*

Mobile No. / *No. Tel. Bimbit*

Email Address / *Alamat Emel*

*Name of Company/Employer / *Nama Syarikat/Majikan*

Date of Employment / *Tarikh Mula Bekerja* dd/mm/yyyy *hh/bb/tttt*

Date of Group Insurance Participation / *Tarikh menyertai Skim Insurans Berkumpulan* dd/mm/yyyy *hh/bb/tttt*

Information Required in Compliance to Goods And Service Tax Act 2014 / ***Maklumat yang Diperlukan Akta Cukai Barangan Dan Perkhidmatan 2014***

Are you GST registered? / *Adakah anda berdaftar untuk GST?*
☐ Yes / *Ya* ☐ No / *Tidak*

If "Yes", please provide us your GST Registration Number. / *Jika "Ya", sila nyatakan Nombor Pendaftaran GST anda.*

Registration Date / *Tarikh Pendaftaran* dd/mm/yyyy *hh/bb/tttt*

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

The Company shall rely on the above information provided by you for tax credit purposes provided under the GST Act. The Company 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 the Company and / or penalties be imposed on the Company by any tax authority for relying on the same, the Company 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. / *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.*

Patient Information (If other than employee) / ***Maklumat Pesakit (Jika lain daripada Pekerja)***

Name of Patient / *Nama Pesakit*

Relationship to Employee / *Hubungan dengan Pekerja*
☐ Self / *Diri Sendiri*
☐ Spouse / *Suami/Isteri*
☐ Child / *Anak*

Patient NRIC No. / *No. KP Pesakit*

Birth Date of Patient / *Tarikh Lahir Pesakit* dd/mm/yyyy *hh/bb/tttt*

Gender of Claimant / *Jantina Pihak Menuntut*
☐ Male / *Lelaki*
☐ Female / *Perempuan*

MC Details / ***Maklumat Cuti Sakit***

Date of MC / *Tarikh Cuti Sakit* To / *Hingga* dd/mm/yyyy *hh/bb/tttt*

No. of MC Days / *Jumlah Hari Cuti Sakit*

For Accidental Cause - Please attach Doctor's Report / ***Untuk Kes Kemalangan - Sila lampirkan Laporan Doktor***

Date of Accident / *Tarikh Kemalangan* dd/mm/yyyy *hh/bb/tttt*

Time / *Masa* ☐ am ☐ pm

Have you/the patient had any prior treatment for this or related conditiion? / *Adakah anda/pesakit mendapat rawatan untuk penyakit ini atau apa-apa keadaan berkaitan sebelum ini?* ☐ Yes / *Ya* ☐ No / *Tidak*

If Yes, please give details: / *Jika Ya, sila nyatakan:*

Details of Other Insurance Policies, Socso, Workmen's Compensation and Others / ***Butir-butir Insurans Lain, Perkeso, Insurans Pampasan Pekerja dan Lain-lain***

Policy Type / *Jenis Polisi*

Policy No. / *No. Polisi*

Insurance Company / *Syarikat Insurans*

☐ Not insured under any program, benefits, schemes or insurance. / *Tidak dilindungi oleh mana-mana syarikat insurans, program, faedah, ataupun skim.*

Payment Details / ***Maklumat Pembayaran***

Payment of Claim is to be made to / *Pembayaran Tuntutan hendaklah dibayar kepada* ☐ Company / *Syarikat* ☐ Employee / *Pekerja*

*Claim Amount / *Amaun yang Dituntut* RM

Submission of Claims - CHECKLIST / ***Penyerahan Tuntutan - SENARAI SEMAK***

☐ Original Receipt (Deposit & Final Payment) / *Resit Asal (Deposit & Bayaran Akhir)*
☐ Itemised Bill / *Bil Terperinci*
☐ Medical Report / *Laporan Kesihatan*
☐ Doctor Prescription / *Preskripsi Doktor*

Section II to be completed / ***Sila lengkapi Bahagian Seksyen II***

- For Government Hospital bill above RM1,000 / *Sekiranya bil melebihi RM1,000 untuk Hospital Kerajaan*
- For Private Hospital bill above RM500 / *Sekiranya bil melebihi RM500 untuk Hospital Swasta*

Note: / *Nota:*

- Documents for each type of claim as stated **MUST** be attached with this form for claim processing. / *Dokumen-dokumen untuk setiap jenis tuntutan seperti yang dinyatakan **MESTI** dilampirkan bersama dengan borang tuntutan ini untuk pemprosesan tuntutan.*
- Claims for medication purchased directly from a pharmacy without a copy of the doctor's prescription slip will **NOT** be processed. / *Tuntutan ubat-ubatan yang dibeli secara terus dari farmasi hendaklah disertakan dengan preskripsi doktor.*
- Each claim form is applicable for **one** admission and related Pre and Post Visit. / *Setiap borang tuntutan adalah untuk **satu** kemasukan ke hospital dan lawatan sebelum dan selepas yang berkaitan dengannya.*
- Claim for hospitalisation & surgical expenses must be submitted within 180 days from date of discharge or consultation. / *Tuntutan hospitalisasi & perbelanjaan pembedahan mesti dihantar dalam masa 180 hari daripada tarikh keluar hospital atau tarikh rundingan.*

Authorisation to Physician, Hospital or Clinic to Release Information / ***Memberi Kebenaran Kepada Doktor Perubatan, Hospital atau Klinik Untuk Memberi Maklumat***

I hereby declare that all information provided in this claim form is complete and true. I hereby authorise any physician, medical practitioner, hospital or clinic by whom or where I/claimant have been observed or treated, to give full particulars about my/claimant's health including my/claimant's whole medical history in respect of this hospitalisation/surgery, to AIA Bhd. A photocopy of this authorisation shall be considered as effective and valid as the original. I understand that this information will be kept strictly confidential by AIA and that AIA undertakes not to disclose this information to any third party without my separate written consent. / *Saya dengan ini mengesahkan bahawa semua maklumat yang diberikan di dalam borang tuntutan ini adalah benar dan lengkap. Saya dengan ini memberi kebenaran kepada doktor perubatan, pengamal perubatan, hospital atau klinik yang merawat saya/pihak menuntut untuk memberi maklumat-maklumat lengkap berhubung dengan riwayat kesihatan saya/pihak menuntut termasuk latarbelakang penuh perubatan saya/pihak menuntut semasa dimasukkan di hospital/menjalani pembedahan kepada AIA Bhd. Salinan surat kebenaran ini adalah dianggap sah dan berkuatkuasa sebagaimana salinan asal. Saya faham bahawa maklumat ini akan dianggap sulit oleh AIA dan AIA tidak akan melepaskan maklumat ini kepada sesiapa tanpa kebenaran bertulis dari saya.*

I agree and authorise AIA to firstly offset any existing indebtedness/claims Shortfall incurred by myself and/or family members, against payable claims (if any) arising from this claim submission. / *Saya dengan ini bersetuju dan memberi kebenaran kepada AIA untuk menyelesaikan sebarang jumlah tunggakan ke atas diri dan tanggungan saya dengan jumlah bayaran dari tuntutan ini.*

Employer's Signature, Stamp & Address
Tandatangan, Cop Rasmi & Alamat Majikan

Signature of Employee / *Tandatangan Pekerja* _____ Date / *Tarikh* _____

SECTION II - To be completed by the Attending Doctor (IN BLOCK LETTERS) **MRN No.:**

Name of Patient

NRIC No.	Date and Time of Admission	Date and Time of Discharge
	d d - m m - y y y y (hrs)	d d - m m - y y y y (hrs)

Name of Referring Doctor and Address

Admitting Doctor	Attending Doctors	Speciality

Symptoms/Conditions requiring admission:	Date first appeared
	d d - m m - y y y y

Any previous consultation/treatment/hospitalisation for this symptom/illness or related conditions,

Date	Disease/Disorder	Details of Treatment/Hospitalisation	Doctor/Hospital

1a) Diagnosis/ICD Coding
i)
ii)
iii)

1b) Cause and Pathology (if applicable) of the above diagnosis

2a) When did patient first consult you for this condition?
d d - m m - y y y y

2b) Was the patient previously treated for this condition by yourself or by any other medical practitioner?
☐ No
☐ Yes, give details and when
_____
_____

2c) How long in your professional opinion has the condition existed?
d d - m m - y y y y

3) Any possibility of relapse?
☐ Yes ☐ No

4a) Please ✓ Nature of Treatment and Investigation:
☐ Operation ☐ Physiotherapy ☐ Dietary Counselling
☐ Medications ☐ X-ray ☐ Blood Tests
☐ Others, give details _____

4b) Please state Type of Procedures/Surgery performed:

Type	Surgical Code	Date	Name of Doctor
i)			
ii)			
iii)			

4c) Other medical conditions present?

5 Was the illness/condition related to: (Please tick ✓ if YES)
a) ☐ Pregnancy _____ weeks
b) ☐ Congenital/Hereditary Disease
c) ☐ Psychotic/Nervous Disorder/Mental/Emotional
d) ☐ Cosmetic Reason/Plastic Surgery
e) ☐ Dental Care/Refractive errors correction
f) ☐ Suicide/Self-inflicted injuries
g) ☐ Childbirth/Fertility
h) ☐ Violation of laws/Strike/Riots

6a) Is the hospitalisation/treatment medically necessary?
☐ No ☐ Yes, please give details
_____
_____

6b) Is it possible to provide this treatment on an outpatient basis?
☐ No ☐ Yes, please give details
_____
_____

7) Did any complications arise during hospitalisation?
☐ No ☐ Yes, please give details
_____
_____

8) Was the patient pregnant at the time of hospitalisation? (For Females Only)
☐ No ☐ Yes, _____ months

9) If the hospitalisation was due to accident, please indicate date/time of accident:
d d - m m - y y y y (hrs)

Discharge/Follow-up instructions

Signature and Name of Attending Doctor _____ Hospital Stamp _____ Date _____

Note: All fields marked with (*) are compulsory. / ***Nota: Semua ruangan bertanda (*) adalah wajib.***