

F. DECLARATION AND AUTHORISATION

- I/We confirm that the information given are true and accurate.
- 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.
- I/We understand AIA PUBLIC 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.
- I/We understand that AIA PUBLIC's acceptance of this Hospital & Surgical Claim Form is not an admission of AIA PUBLIC'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 PUBLIC or its representative.
- I/We understand and agree that any personal information collected or held by AIA PUBLIC (whether contained in this application or otherwise obtained, including through credit reporting agencies) may be held, used, and disclosed by AIA PUBLIC to individuals/organizations related to and associated with AIA PUBLIC or any selected third party (within or outside of Malaysia, including but not limited to retakaful and claims investigation companies, industry associations/federations and credit reporting agencies) for the purpose of (a) processing this application; (b) providing subsequent service for this; (c) for AIA PUBLIC data matching; and (d) to review and advise on my/our coverage with AIA PUBLIC. I/We understand that I/we have a right to obtain access to and to request correction of any personal information held by AIA PUBLIC concerning me/us. Such request can be made to any of AIA's Customer Centre.

Signature of Person Covered

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 <input type="checkbox"/> Male <input type="checkbox"/> Female
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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]
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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 [] [] []
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5. a) Symptoms / Conditions requiring admission:	b) How long is patient aware of the condition:
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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]
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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: <u>Date</u> <u>Disease / Disorder</u> <u>Details of Treatment / Hospitalisation</u> <u>Doctor / Hospital / Clinic</u>
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d) Can the condition be managed under the Outpatient basis: <input type="checkbox"/> Yes <input type="checkbox"/> No
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If No, please provide reasons of admission: _____

7. Any other medical / surgical conditions present? <input type="checkbox"/> No <input type="checkbox"/> Yes, details below:
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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:
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9. Treatment given / Investigation done (Please supply copy of all investigation results):
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10. a) Surgical procedures performed: MMA code / PHFSR code:	b) Date of surgery / procedure: [d][d] - [m][m] - [y][y][y][y]
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11. Is the illness / condition related to: (please tick ✓ if YES)	e) <input type="checkbox"/> Cosmetic Reason / Dental Care / Refractive Errors Correction
a) <input type="checkbox"/> Childbirth / Infertility / Caesarean Section / Miscarriage or Any Complications Arising Therefrom	f) <input type="checkbox"/> AIDS / STD / VD / HIV
b) <input type="checkbox"/> Congenital / Hereditary Disease	g) <input type="checkbox"/> Self-inflicted Injuries / Violation of Laws / Strike / Riots
c) <input type="checkbox"/> Influence of Drugs / Alcohol	h) <input type="checkbox"/> None of the above
d) <input type="checkbox"/> Nervous / Mental / Emotional / Sleeping Disorder	

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