



redefining / insurance

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Co.Reg No. 199903512M

Inpatient/Day Surgery  
Claim Form  
Policy No.

Inpatient Claim/Day Surgery Claim     Health Cash Claim     Special Grant Claim (For Smart Care Policy only)

A. Employer (For Group Policy)

Full Name

B. Policyholder's (For Individual Policy)/Employee's (For Group Policy) Particulars

Full Name     NRIC/FIN/Passport No.

Date of Birth (DD/MM/YYYY)     Nationality

Contact Number (Mobile)     Gender  Female     Male

Email

C. Patient's Particulars (If Patient is a dependent of the Policyholder/Employee)

Full Name

Relationship  Spouse     Child    NRIC/FIN/Passport No

Date of Birth (DD/MM/YYYY)     Gender  Female     Male

D. Please complete if Inpatient/Day Surgery was due to Accident (if applicable)

Date of Accident (DD/MM/YYYY)     Time of Accident

Place of Accident

Describe how the accident happened (Please enclose a copy of the police report, if any)

Describe in details the injury(s) sustained, indicating the part of the body injured and the type of injury (eg. fracture, cut, bruise etc.)

Was it work related?  Yes     No

Are you entitled to claim against Work Injury Compensation?  Yes     No

### E. Please complete if Inpatient/Day Surgery was due to Illness (if applicable)

Nature of sickness (describe the symptoms suffered)

Date symptoms first started (DD/MM/YYYY)

Date of first consultation with a doctor for this condition (DD/MM/YYYY)

Has the patient ever seen a doctor for any similar conditions in the past?  Yes  No

Name of doctor

Address of doctor/hospital

### F. Please provide these additional information if Inpatient/Day Surgery was outside Singapore (if applicable)

Purpose of the overseas trip

Date of departure and return to Singapore/own area of cover (Pls provide proof of travel e.g Flight details/passport copy)

From

To

### G. Please complete if you are making a Special Grant claim (For Smart Care Policy only)

Date of death (dd/mm/yyyy)

Place of death

(Pls specify name of hospital if death occurred in hospital)

Cause of death

### H. Other Information

Have you claimed or do you intend to claim from any insurer, other employer or any parties for reimbursement of your medical bills?

Yes  No

If 'yes', please state the party that you are claiming from and submit a copy of the settlement letter or payment voucher from the other party?

Note: it is important that you inform us if you are claiming from another insurer, other employer or any other parties for the same bill(s). You can only be reimbursed once for the amount that you have incurred regardless of the number of medical insurance policies you may have. We reserve that right to recover if there is any excess amount paid to you.

Are you claiming for cash benefit for your Inpatient claim? (For International Exclusive Policy)

Yes  No

Note: This benefit is payable provided we do not bear the cost of your Inpatient claim

### I. To be completed by employer ( Applicable for Smart Care Headcount Policy only)

Company Name

Plan No./Plan Type

Date of employment (DD/MM/YYYY)

Designation/Grade of Employee

Effective date of coverage (DD/MM/YYYY)

Date (DD/MM/YYYY) , Signature of Employer and Company Stamp

## J. Payment Details

1. Benefits should be made payable to

Policyholder/Employer       Claimant/Employee       Third Party (For International Exclusive Policy only)

2. Payment is to be made by

Cheque       Direct Credit (For International Exclusive Policy only)

Overseas Telegraphic Transfer (For International Exclusive Policy)

Name of Bank  Name of Account Holder

Bank Code  Branch Code  Account Number

**For overseas telegraphic transfer, please provide these additional information**

Bank Address

IBAN/SWIFT Code

## K. DECLARATION, AUTHORIZATION & CUSTOMER'S DATA PRIVACY CONSENT

**[Declaration]** I/We confirm that I am/We are the claimant and/or the Policyholder and I/We declare that all the particulars given above are to the best of my/our knowledge true and correct.

**[Authorization]** I / We hereby consent to and authorize the medical practitioner involved in the claimant's care to discuss and disclose treatment details and discharge arrangements with and to AXA Insurance Pte Ltd. I/We agree that a copy of this consent shall have the validity of the original.

**[Customer's Data Privacy Consent]** In connection with my/our and/or the claimant's claims, I/We give consent for AXA Insurance Pte Ltd ("AXA") and their respective representatives or agents to collect, use, store, transfer and/or disclose the information (including that provided by sources other than myself) concerning me/us and/or the claimant, to or with all such persons (including any member of the AXA Group or any third party service provider, and whether within or outside of Singapore and the Policyholder when claiming under a Group Policy) for the purpose of enabling AXA and their respective representatives or agents to provide me/us and/or the claimant (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/or managing my/our and/or the claimant's claims or the Policyholder Group Policy(ies) with AXA (as the case may be), and for the purposes set out in AXA's Data Use Statement which can be found at <http://www.axa.com.sg> ("Purposes").

Full Name, NRIC/Fin/PP no. & Signature of Claimant/Employee  
(Parent's or Guardian's signature if patient is a minor)

Date (DD/MM/YYYY)

Full Name, NRIC/Fin/PP no. & Signature of Patient  
(Parent's or Guardian's signature if patient is a minor)

Date (DD/MM/YYYY)

## L. TRACK YOUR CLAIM STATUS

Should you have any query on your claim status, please contact us at the following

[www.axa.com.sg](http://www.axa.com.sg) (File a Claim)      [1800 880 4888](tel:18008804888)      [customer.care.health@axa.com.sg](mailto:customer.care.health@axa.com.sg) (Smart Care Policy)  
[\(65\)6322 2555](tel:6563222555)      [ops@ipa.sg](mailto:ops@ipa.sg) (International Exclusive Policy)

AXA Insurance is committed to making your claim submission simple and easy.

Thank you for insuring with AXA Insurance, we are proud to serve you.



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Medical Report  
Policy No.

To be completed by your treating doctor if you have attended a private hospital or a hospital outside Singapore

1. Name of Patient

2. NRIC/FIN/Passport No.

3. Date admitted  (DD/MM/YYYY)      Date discharged  (DD/MM/YYYY)

4. Was patient referred to you by another doctor?  Yes  No

If "Yes", please state date of referral and provide us with the name and address of referring doctor.

Date of Referral  (DD/MM/YYYY)      Name of Doctor and address of clinic

5. When did patient first consult you for the condition? Date of first consultation (DD/MM/YYYY)

6. What were the complaints or symptoms presented during the first consultation?

7. When did patient first experience these complaints or symptoms? Date of first consultation (DD/MM/YYYY)   
If there were no complaints or symptoms, what prompted the patient to see you?

8. In your expert opinion, per history provided to you by patient and given the etiology of the condition, please state the estimated duration of such condition would be in existence for this patient.

9. Has patient received any prior treatment for these complaints or symptoms?  Yes  No

If "Yes" please state when and provide us with the name and address of doctor who treated patient previously.

10. Principal Diagnosis

Diagnosed Condition(s)	ICD 10 Code	Date of First Diagnosis (DD/MM/YYYY)	Date Patient Informed of Diagnosis (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Other diagnosis(es)

Diagnosed Condition(s)	ICD 10 Code	Date of First Diagnosis (DD/MM/YYYY)	Date Patient Informed of Diagnosis (DD/MM/YYYY)

Note: If there is more than one diagnosis, please advise whether they are related directly to each other. If yes, please provide us with details to your answer.

Yes  No

11. What was the underlying cause(s) of the diagnosed condition(s) as stated in Question 10?

  

12. Did patient suffer or is suffering from any other co-morbidity (ies) that is/are related to diagnosed condition(s)?

Yes  No If 'Yes', please specify

Co-morbidity(ies)	Date of treatment	Name and address of doctor

13. Was surgery performed for the diagnosed condition(s)?

Yes  No If 'Yes', please specify

Date of Surgery	TOSP Code	Table	Description

14. If 2 or more surgeries were performed, please specify whether they were done through same incision.

15. If no surgery was performed, please state treatment and medication given.

If patient was admitted for a maternity condition, please complete this section

16. a) Patient's LMP (DD/MM/YYYY)

b) Is the pregnancy a result of any infertility treatment including infertility medication or conception by artificial means?

Yes  No If "Yes", please provide details to your answer

  

c) Type of delivery  Vaginal Delivery  Elective Caesarean Section  Emergency Caesarean Section

If Emergency Caesarean Section, please advise reason(s)

d) Did any complications arise during pregnancy?  Yes  No If 'Yes', please provide details to your answer

**If patient was admitted for miscarriage, please complete this section**

17. Was it due to an accident?  Yes  No

If yes, please describe how it happened?

If no, please state the cause of the miscarriage?

**If patient was admitted due to an accident, please complete this section**

18. Was the treatment related to accident?  Yes  No

Date of accident (DD/MM/YYYY)

Road traffic accident  Work related accident  Others If 'Others', please specify

Please describe how it happened?

**Was patient's diagnosed condition(s)/ surgery(ies)/ treatment due to or related to any of the following**

19. Dental condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	A psychiatric condition	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abortion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol Dependence/Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infertility/Sub-fertility/ Impotence/ Contraception/ Sterilisation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnoea/Sleep Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Self-inflicted injury/Attempted Suicide	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sexually transmitted disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Refractive error of the eye(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS or HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity/ Weight Reduction/Weight Improvement	<input type="checkbox"/> Yes <input type="checkbox"/> No
A congenital condition	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Learning disorder/Behavioural problem/Physical & Psychological development problem			<input type="checkbox"/> Yes <input type="checkbox"/> No

20. Was the treatment a/ an

Experimental medical treatment  Cosmetic/ Plastic surgery

If you have ticked any boxes, please give details of the treatment(s)/surgery(ies).

  


21. Any other information that may assist us in the assessment of the claim.

I hereby certify that I have personally examined and treated the patient in connection to the above condition(s) and the facts as given above represent my opinion of his/ her condition. I declare and agree to make the declaration on this claim form.

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Doctor

\_\_\_\_\_  
Hospital/Clinic stamp