

**AXA INSURANCE SINGAPORE PTE LTD**  
 143 Cecil Street #01-01 GB Building  
 Singapore 069542  
 Tel: (65) 6338 7288 Fax: (65) 6338 2522 [www.axa.com.sg](http://www.axa.com.sg)



**COMBINED CLAIM FORM**

**Please send claim form and documents to:**

**AEGIS INSURANCE SERVICES PTE LTD**  
 15 Queen Street, #03-07 Tan Chong Tower  
 Singapore 188537  
 Tel: (65) 6837 0306 Fax: (65) 6837 0305  
[Email: customerservice@aeqisic.com](mailto:customerservice@aeqisic.com)  
[www.aeqisic.com](http://www.aeqisic.com)

**Please complete this claim form fully.**  
**Incomplete forms may delay claim settlement.**

**TYPE OF CLAIM & CHECKLIST (please select)**

<input type="checkbox"/> <b>Hospitalisation &amp; Surgical</b> <input type="checkbox"/> Completed Claim Form <input type="checkbox"/> Original Final Medical Bills & Receipts <input type="checkbox"/> Medical Report/Discharge Summary/Day Surgery Authorisation Form	<input type="checkbox"/> <b>Outpatient GP/A&amp;E</b> <input type="checkbox"/> Completed Claim Form <input type="checkbox"/> Original Medical Bills & Receipts
<input type="checkbox"/> <b>Personal Accident</b> <input type="checkbox"/> Completed Claim Form <input type="checkbox"/> Original Medical Bills & Receipts <input type="checkbox"/> Doctor's Memo providing description injury & treatment (if available) <input type="checkbox"/> Police Report (for traffic accidents)	<input type="checkbox"/> <b>Outpatient Specialist</b> <input type="checkbox"/> Completed Claim Form <input type="checkbox"/> Original Medical Bills & Receipts <input type="checkbox"/> Referral Letter From GP <input type="checkbox"/> Doctor's Memo providing description of condition & treatment (if available)

<b>PEI Name :</b>	<b>Policy Number(s) :</b>
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<b>SECTION A DETAILS OF INSURED PERSON (STUDENT)</b>			
Name of Insured Student (as per bank account)	Passport No.	Student ID No/FIN No.	Date of Admission to School
Please tick to select status <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part Time Student		Please tick to select status <input type="checkbox"/> Singapore Citizen/PR <input type="checkbox"/> International (non STP) <input type="checkbox"/> International (STP)	
E-mail	Telephone No.	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (in Singapore)		Please settle claim payment by : <input type="checkbox"/> credit to student's bank* <input type="checkbox"/> by cheque to student <input type="checkbox"/> others _____ (*for outpatient claims only if applicable)	

<b>SECTION B DETAILS OF STUDENT'S BANK ACCOUNT - Please complete if you tick claim payment by credit to student's bank (For Outpatient claims only)</b>		
Bank Name (please tick) <input type="checkbox"/> DBS/POSB <input type="checkbox"/> UOB <input type="checkbox"/> OCBC <input type="checkbox"/> others	Branch	Account No. 

<b>SECTION C DETAILS OF ILLNESS</b>	
1. Nature of Illness/Symptoms/Final Diagnosis	2. Date Symptoms First Noticed
3. Type of Treatment/Operation	4. Date First Treated    5. Hospitalisation Period

<b>SECTION D DETAILS OF ACCIDENT</b>			
1. Description of Accident (how it happened)	2. Place of Accident	3. Date of Accident	4. Time of Accident
5. Nature of Injury	6. Treatment/ Operation	7. Hospitalisation Period	8. Is this a job-related injury <input type="checkbox"/> No <input type="checkbox"/> Yes

<b>SECTION E OTHER INFORMATION</b>	
1. Has the illness been treated before? Has the same part been injured before? <input type="checkbox"/> No <input type="checkbox"/> Yes, please state date first occurred	2. Are you making a claim for this treatment from any other insurance company? <input type="checkbox"/> No <input type="checkbox"/> Yes, please state name of insurer
3. Name & Address of Attending Doctor/Clinic/Hospital	

<b>SECTION F DECLARATION &amp; AUTHORISATION</b>	
I hereby authorise any hospital, physician, person or organisation who has attended to or examined me, or is authorized to maintain medical records, to disclose when requested to do so by AXA Insurance Singapore Pte Ltd any and all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original. I hereby declare that the above information, statements answers are true and complete to the best of my knowledge and belief. I agree that if I have made, of if I shall make, any false or untrue statement, suppression or concealment, the Policy shall be void and all rights to compensation shall be absolutely forfeited.	
Signature of Insured Student	Date

<b>TO BE COMPLETED BY SCHOOL/PRIVATE EDUCATION INSTITUTION</b>		
Is student registered with PEI on date of accident/illness? <input type="checkbox"/> No <input type="checkbox"/> Yes	Verified and Witnessed by PEI:  Sign & Stamp	Name of Authorised Officer (PEI):  Designation of Authorised Officer (PEI):

## MEDICAL CERTIFICATION OF TREATMENT

**SPECIAL INSTRUCTION:**

**(GROUP SCHEME MEMBERS):** Please arrange for this Medical Certification of Treatment to be completed by your treating doctor if you have attended a Private Hospital or Hospital outside Singapore.

**(INDIVIDUAL SCHEME MEMBERS):** Please arrange for this Medical Certification of Treatment to be completed by your medical practitioner for treatment in all hospitals.

<b>1. Name of patient:</b>	<b>NRIC:</b>
<b>2. Full description of diagnosis (based on ICD, 1975 revision, WHO)</b>	
a) Principal diagnosis:	ICD CODE <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/>
b) Other diagnosis:	ICD CODE <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/>
<b>3. What is the cause of the illness/injury?</b>  _____	
<b>4. Has the patient suffered or is suffering from any other medical condition(s) that is/are related to the diagnosis in Question 2?</b> If yes, please give details & when the condition(s) manifested.  _____  _____	<input type="checkbox"/> YES <span style="margin-left: 200px;"><input type="checkbox"/> NO</span>
<b>5. Is this treatment related to:</b> i) Sleep Apnea ii) Obesity iii) Weight Reduction/Improvement	<input type="checkbox"/> YES <span style="margin-left: 200px;"><input type="checkbox"/> NO</span>
<b>6. Is this treatment related to</b> a) pregnancy or childbirth? b) abortion or miscarriage? If related to miscarriage, was it due to accident?	<input type="checkbox"/> YES LMP: <span style="margin-left: 200px;"><input type="checkbox"/> NO</span> <input type="checkbox"/> YES <span style="margin-left: 200px;"><input type="checkbox"/> NO</span> <input type="checkbox"/> YES <span style="margin-left: 200px;"><input type="checkbox"/> NO</span>
<b>7. Will the patient be required to undergo</b> a) Normal Delivery b) Elective Caesarean If Elective Caesarean, please state the reason.  _____  _____	<input type="checkbox"/> YES <span style="margin-left: 200px;"><input type="checkbox"/> NO</span> <input type="checkbox"/> YES <span style="margin-left: 200px;"><input type="checkbox"/> NO</span>
<b>8. Is this treatment</b> a) related to infertility/subfertility condition? b) done to correct infertility/subfertility condition?	<input type="checkbox"/> YES <span style="margin-left: 200px;"><input type="checkbox"/> NO</span> <input type="checkbox"/> YES <span style="margin-left: 200px;"><input type="checkbox"/> NO</span>
<b>9. Is this due to self-inflicted injury or sexually transmitted disease?</b>	<input type="checkbox"/> YES <span style="margin-left: 200px;"><input type="checkbox"/> NO</span>
<b>10. Is this condition</b> a) a congenital anomaly? b) a mental or nervous disorder? c) a refractive error of the eye?	<input type="checkbox"/> YES <span style="margin-left: 200px;"><input type="checkbox"/> NO</span> <input type="checkbox"/> YES <span style="margin-left: 200px;"><input type="checkbox"/> NO</span> <input type="checkbox"/> YES <span style="margin-left: 200px;"><input type="checkbox"/> NO</span>

<p><b>11. Is this</b></p> <p>a) a cosmetic surgery? If No, Please explain _____</p> <p>b) an oral surgery?</p> <p>c) a dental surgery/treatment?</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>																
<p><b>12. Is this a job-related injury?</b></p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>																
<p><b>13. Has the patient ever had the same or similar condition / symptoms?</b> If yes, please indicate when and describe.</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>																
<p><b>14. Doctors previously consulted by the patient for the above condition(s).</b></p>																	
<p><b>15. Please indicate approximate date from which the patient first notice symptoms of condition.</b></p>	<p><input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/></p>																
<p><b>16a. What symptoms did the patient present?</b></p>																	
<p><b>16b. How long had the patient been troubled by them?</b></p>	<p><input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/></p>																
<p><b>17. Date you were first consulted for this condition.</b></p>																	
<p><b>18a. Date of diagnosis for this condition.</b></p>	<p><input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/></p>																
<p><b>18b. Date patient was informed of your diagnosis</b></p>	<p><input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/></p>																
<p><b>19. How long had has the injury / illness been existing prior consulting you?</b></p>																	
<p><b>20. Surgical operations performed on patient</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;"><u>*Operation Code</u></th> <th style="width: 35%;"><u>Type of Operation</u></th> <th style="width: 15%;"><u>*Table</u></th> <th style="width: 25%;"><u>Date Performed</u></th> </tr> </thead> <tbody> <tr> <td><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/></td> <td>_____</td> <td>_____</td> <td><input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/></td> </tr> <tr> <td><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/></td> <td>_____</td> <td>_____</td> <td><input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/></td> </tr> <tr> <td><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/></td> <td>_____</td> <td>_____</td> <td><input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/></td> </tr> </tbody> </table> <p>_____ Date _____ Signature of Physician/Surgeon and Official Stamp.</p> <p>Name of Physician/Surgeon Address</p> <p><small>* This applies to operations carried out in S'pore only and refers to the classification in the Medisave table of surgical operations for private hospital.</small></p>		<u>*Operation Code</u>	<u>Type of Operation</u>	<u>*Table</u>	<u>Date Performed</u>	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	_____	_____	<input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	_____	_____	<input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	_____	_____	<input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>
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