AIA SINGAPORE
SINGTEL ACTIVE PROTECT CLAIM FORM
Corporate Solutions
3 Tampines Grande, #07-00, AIA Tampines, Singapore 528799, Fax: 6538 5603 / 6538 4340, Email : sg.cs.campaign@aia.com

CLAIM PROCEDURES

FOR OUTPATIENT MEDICAL REIMBURSEMENT BENEFIT CLAIM (DUE TO ACCIDENT)

Please furnish the following documents within 30 days from date of incurred :-

a) Duly completed Section 1 of the Claim Form*
b) Original Tax Invoice*
c) This benefit will be payable up to the benefit limit per visit capped at 3 visits per year
d) Claims settlement (if payable) will be made payable to the insured member

FOR LOSS OF PORTABLE ELECTRONIC DEVICE BENEFIT CLAIM

Please furnish the following documents within 30 days from date of loss :-

a) Duly completed Section 1 of the Claim Form*
b) Copy of Tax Invoice / Proof of Purchase*
c) Copy of Police Report*
d) This benefit will only be payable up to the benefit limit per insured person regardless of the number of occurrences.
e) Claims settlement (if payable) will be made payable to the insured member

FOR PERSONAL ACCIDENT – DEATH CLAIM

Please furnish the following documents within 30 days from date of death :-

a) Duly completed Section 1 of the Claim Form*
b) Duly completed Physician's Statement (including any other medical evidence) by the Attending Physician / Surgeon*
c) Copy of Death Certificate*
d) Copy of Police Report / Investigation Report*
e) Copy of Post Mortem / Autopsy Report including Toxicology Report (if any)
f) Copy of Coroner's inquest / Verdict (if any)
g) Certified True Copy of Claimant's identity card (front and back)
h) Copy of Letter of Administration / Grant of Probate (if any)
i) Any other documents required, will be based on the case itself.
j) Every question must be distinctly and fully answered. The company reserves the right to pursue or obtain further information / document should it be deemed necessary.
k) Claims settlement (if is payable) will be made payable to the Estate of the Insured Person via cheque.

IMPORTANT NOTE

- Cost of Medical Report and/or medical evidence shall be borne by the Insured Person / Claimant.
- AIA reserves the right to pursue or obtain further information / document should it be deemed necessary.
- * Denote as Mandatory documents required for claim adjudication failing which the Insurer reserves the rights to reject the claim submission.

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Section 1 - Claimant's Statement

Please tick the applicable claim type and refer to page 1 for the claim requirements :

☐ **Outpatient Medical Reimbursement** ☐ **Loss of Portable Electronic Device** ☐ **Personal Accident Death Claim**

Part A : To be completed by Claimant / Insured Member			
1) Name of Claimant		Claimant's NRIC / Passport No.	
Relationship to Insured Member	Contact No.	Email Address	
2) Name of Insured Member		NRIC / Passport No.	Date of Birth (DD/MM/YY)
Email Address		Gender ☐ Female ☐ Male	
Mailing Address for Claims Settlement Correspondence			

Part B : Claims Payment Details (For Outpatient Medical Reimbursement & Loss of Portable Electronic Device Benefit)					
Bank Name		Branch Code		Bank A/C No.	

Part C: Details of Outpatient Medical Consultation			
Date of Consultation (DD/MM/YY)		Date of Accident (DD/MM/YY)	
Clinic Name			
Final Diagnosis			
Details of Accident			

Part D: Details of Loss of Portable Electronic Device			
Date of Loss (DD/MM/YY)		Place of Loss (DD/MM/YY)	
Description of Device		Date of Purchase	Purchase Price

Part E : Details of Death			
Date of Death (DD/MM/YY)		Place of Death	
Cause of Death			
Date of Accident (DD/MM/YY)		Place of Accident	

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Part F : Declaration and Authorisation

1) I/We acknowledge and accept that the furnishing of this form, or of any other forms supplemental thereto, by AIA Singapore Private Limited ("AIA Singapore") is neither an admission that there was any insurance in force on the life in questions, nor an admission of liability nor a waiver of any of its rights or defences.

2) I/We declared that I/we am/are not an undischarged bankrupt. There are currently no actual or pending bankruptcy proceedings against me/us.

3) I/We
   a) hereby declare that I/we are duly authorised to make this claim and all statements and responses whether on this form or otherwise together with any required questionnaire, amendments, materials and supporting documents submitted in connections with the claim and the Policy ("Information");
   b) declare that all information is complete, true and correct and that no information or materials have been withheld and that AIA Singapore will rely and act on the Information accordingly. Otherwise, AIA Singapore shall be at liberty to deny liability or recover amounts paid whether wholly or partially;
   c) acknowledge and accept that AIA Singapore shall be a liberty to deny liability or recover amount paid, whether wholly or partially, if any of the information is incomplete, untrue or incorrect in any respect of if the Policy does not provide cover on which such claim is made; and
   d) acknowledge and accept that AIA Singapore expressly reserves its rights or obtain further information as it deems necessary.

4) I/We hereby authorize, agree and consent to AIA Singapore to request from any hospital, physician, person or organization, all information with respect to any illness, injury, medical history, and copies of all hospital or medical records concerning myself at any time and authorize the prior mentioned organizations to disclose all such information to AIA Singapore.

5) I/We consent to AIA Singapore, its associated persons/organisations, third party service providers and representatives, whether within or outside Singapore (collectively "**AIA Persons**") to collect, use, disclose, store, retain and/or process (collectively, "**Use**") all personal data and information ("**Personal Data**") provided to AIA Persons or that they possess about me/us, in the manner and for the purposes described in the AIA Personal Data Policy ("**PD Policy**") which is available on AIA Singapore's website.

6) I/We agree to accept the provisions in the PD Policy as amended from time to time. Where Personal Data of another person is disclosed by me/us, I/we confirm that I/we have obtained the consent of the individual concerned, except to the extent such consent is not required under relevant laws to collect, use and/or disclose such Personal Data. I/We waive (on my/our own behalf and on behalf of each such other person) any right to claim against any of the AIA Persons for any Use in the nature of or for the purposes described above or in the PD Policy. I/We will indemnify AIA Persons for all losses and damages if I/we breach these provisions.

7) This consent shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not our Application/form is accepted by AIA Singapore. A photocopy of this consent shall be valid and effective as the original.

Signature of Insured Member / Claimant	Relationship to Insured Member	Date (DD/MM/YY)

Part G : Declaration on U.S. Person Status (please tick the box as appropriate)

☐ I/We hereby declare and agree that I am/we are not a "U.S. person" for U.S. federal income tax purposes and that I am/we are not acting for, or on behalf of a U.S. person. I/We understand that AIA Singapore, believing this statement to be true, will rely on it and act on it. In the event this statement is false, AIA Singapore reserves the right and shall be entitled to cancel or terminate this Policy/Policies and pay reasonable compensation to me/us in consideration of such cancellation or termination as may be required under Singapore laws.

I/We agree to notify AIA Singapore within 30 days of any change in my/our status as a U.S. person for the purposes of U.S. federal income tax. I/We agree to indemnify AIA Singapore in respect of any false or misleading information regarding my/our "U.S. person" status for U.S. federal income tax purposes.

☐ I/We hereby declare and agree that I am/we am a "U.S. person" for U.S. federal income tax purposes. I agree to notify AIA Singapore within 30 days of any change in my/our status as a U.S. person for the purposes of U.S. federal income tax. I/We agree to indemnify AIA Singapore in respect of any false or misleading information regarding my/our "U.S. person" status for U.S. federal income tax purposes.

Note: Please submit duly completed W-9 form to us. You can download a copy of the W-9 form from our corporate website www.aia.com.sg

Signature of Insured Member / Claimant	Relationship to Insured Member	Date (DD/MM/YY)

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Section 2 : Physician's Statement – For Death Claim

To be completed by Attending Physician **(The medical report fee, if any, will be borne by the Claimant)**

Name of Deceased	Occupation	NRIC / Passport No.

1) Date of Death	2) Place at time of death
3) What was the immediate Cause of Death?	4) How long has the illness existed prior to Death?
5) Did Deceased have any symptoms prior to Death? ❒ Yes ❒ No If Yes, Date symptoms first started : Nature of Symptoms :	6) When did Deceased first consult you for this condition? Date : When did Deceased last consult you for this condition? Date :
7) When was the diagnosis leading to the cause of Death first diagnosed? Date :	8) Was Deceased informed of the diagnosis? ❒ Yes ❒ No If Yes, when was the Deceased first told? :

9) Did Deceased suffer from any other illness?

Illness	Period Of Illness	Date of Diagnosis	Date & Type of Treatment

10) Was the Death in any way partly attributed to Deceased's habits, family history, occupation OR previous diseases? ❒ Yes ❒ No
If Yes, give details :

11) Was there any predisposing caused of the deceased's death in his / her habits (use of alcohol, narcotics, etc) family history, occupation or previous sickness?

12) Name and address of all physicians who previously consulted by Deceased for the above condition.

Name of Physician	Name & Address of Clinic	Date of Attendance

I hereby declare that I was physician in attendance during the last illness of the deceased and that the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from the Company.

Signature of Physician / Surgeon

Date (DD/MM/YY)

Name / Designation

Name and Address of Clinic / Hospital & Stamp