



Statement of Claim

INSTRUCTIONS

1. This form must be fully completed to avoid any delay in the settlement of claim, and must be signed at both places provided for.
2. Itemised original bills and receipts covering hospitalisation and surgical expenses for which claim is made must be attached.
3. If the patient/covered person is a child, the Insured/policyholder should sign the statement of consent.

A. INSURED/COVERED PERSON

Name of Insured:	Name of Policyowner:
NRIC/Passport No.:	Policy No.:
Employment date: dd/mm/yy	Plan No.:

B. CLAIMANT'S DETAILS

Name of Claimant:					
Claimant is: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child			NRIC/Passport/Birth Cert. No.:		
Date of birth: dd/mm/yy	Age:	Sex:	Race:	Religion:	
Marital status:	Contact No.:	Occupation:			
Employer:					
Employer's address:					

C. ACCIDENT (Please complete if applicable)

Date: dd/mm/yy	Time: am/pm	Place:	At work: Yes <input type="checkbox"/> No <input type="checkbox"/>
State how it happened:			
Nature of injury sustained:			

D. SICKNESS (Please complete if applicable)

Nature of illness:	
Date first began: dd/mm/yy	Date first treated: dd/mm/yy
Has this condition been treated previously? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please name the doctor and address)	

E. OTHER INFORMATION (Must be fully completed)

Name of hospital/clinic:		
Address of hospital/clinic:		
Date admitted/treatment: dd/mm/yy	Date discharged (if hospitalised): dd/mm/yy	Date surgery performed: dd/mm/yy
Has claim been filled for Workmen's Compensation/Social Security? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, will such claim be filled? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Is this a continuation of previous or current treatment for which you have already claimed under this Policy? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please give details below)		
Claim No.:	Date of disability: dd/mmyy	Claim amount: RM
Give details of other health insurance cover (if any):		
Claim payment in favour of? (Please specify the name of Payee)		
<input type="checkbox"/> Hospital _____ <input type="checkbox"/> Employer _____ <input type="checkbox"/> Doctor _____ <input type="checkbox"/> Employee/Claimant/Insured _____ <input type="checkbox"/> Other _____		
Type of claim:		
<input type="checkbox"/> In-patient hospitalisation <input type="checkbox"/> Pre-hospitalisation <input type="checkbox"/> Post-hospitalisation <input type="checkbox"/> Accident related <input type="checkbox"/> Government hospital cash daily allowance (if applicable) <input type="checkbox"/> Day surgery <input type="checkbox"/> Outpatient cancer treatment/kidney dialysis (if applicable) <input type="checkbox"/> Others: _____		

F. AUTHORISATION TO RELEASE INFORMATION

I hereby authorise any physician, hospital, clinic, insurance company or any organisation, institution or person to give full particulars about my health including my/ward's whole medical history and billing information in respect of this hospitalisation/surgery to AXA Affin General Insurance Berhad. I further consent to the redisclosure of all such medical information and records to insurers, re-insurers, solicitors, my employer, agents/brokers and other third parties in connection with my insurance claims. A duplicate of this authorisation shall be as effective and valid as the original.

Signature of Insured/Claimant:

Signature of Policyowner:

Date:

G. MEDICAL REPORT (To be completed by the patient's physician or surgeon)

Note for hospital - To expedite settlement of the Claim, please answer all questions herein and attach all of your bills and/or receipts covering all hospital charges incurred during the confinement.

Name of patient:		
NRIC/Passport/Birth Certificate No.:	Sex:	Age:
Name of hospital:		
Date and time of admission: dd/mm/yy am/pm	Date and time of discharge: dd/mm/yy am/pm	
Reason for admission/symptoms:		
Vital signs: Temperature: _____ Pulse: _____ TPR: _____ BP _____		
Provisional diagnosis:	Date you were first consulted: dd/mm/yy	
Have you seen this patient before for other problems? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please give date and type of problem)		
Was this patient referred to you? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please provide doctor's name and address or the referral letter)		
Has the patient ever had the same or similar condition? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please state when)		
How long in your professional opinion has the condition existed? _____ days _____ months _____ years		
Name and address of doctors previously consulted by the patient for the condition:		
Final diagnosis/ICD Coding:		
Cause and pathology (if applicable) for the above diagnosis:		
Type of investigation and result:		
Is this admission primarily for investigation? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Treatment required:		
Please state type of procedure performed:		
Procedure type	Name of doctor	Reason for procedure done
Other medical conditions or underlying disease present?		
Medical condition	Since (dd/mm/yy)	
Insured's past medical history (if any):		
Was the condition related to:		
Congenital/Hereditary <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnancy/Childbirth or Infertility <input type="checkbox"/> Yes <input type="checkbox"/> No	
Anxiety/Mental disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Cosmetic/Plastic surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	
Self-inflicted/Drugs or Alcohol abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Routine health screening <input type="checkbox"/> Yes <input type="checkbox"/> No	
STD/AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No		
Can this sickness or injury be treated as an:		
Outpatient basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Day surgery basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(If no, please provide details)		
Was the patient pregnant at the time of the hospitalisation? (For female patient only) <input type="checkbox"/> Yes _____ months <input type="checkbox"/> No		
Any possibility of a relapse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is follow-up required? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If the hospitalisation was due to accident, please indicate:		
Date: dd/mm/yy	Time: am/pm	
Nature of accident:		
Extent of injury:		
Medication on discharge:		
I hereby certify that the answers above are full, complete and true.		
Date:	Signature, name and address of physician:	