PROHEALTH
MEDICAL CLAIM FORM

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PROHealth

Instructions for completing the PROHealth Claim Form

Sections A and B: To be completed and signed by the Policyholder for **ALL** claims.

Section C: To be completed and signed by the Attending Physician in any of the situations stated on the right. Please complete the International Classification of Diseases (ICD) 10 Code, as this is a mandatory field.

- If the Attending Physician is a Specialist
- If the patient received treatment in a hospital facility
- If a laboratory test, diagnostic or surgical procedure was performed
- If the Attending Physician has not provided a diagnosis of the patient's condition in any of the supporting invoices or receipts

SECTION A

Policyholder Information

Name of Patient: _____

Identity Card Number: _____

Policyholder Name: _____

Policy Number: _____

ID Number: _____

Social Security No.: (If U.S. Citizen) _____

Address: _____

Country: _____

Postal Code: _____

Telephone: _____

Email: _____

Claim Settlement

Account Name: _____

Bank Account No: _____

Name of Bank: _____

Bank Address: _____

Sort / Swift Code: _____

SECTION B

To be answered by the Policyholder (or parent/guardian if a minor)

(I) If this claim pertains to Illness:	(II) If this claim pertains to an Accident, please complete both I & II
1. What is the doctor's diagnosis?	1. What is the nature of this injury?
2. When was this condition first diagnosed?	2. Date, time, and exact place of Accident:
3. How long has the symptoms been present before treatment was sought?	3. Briefly describe how this Accident occurred:
4. Describe briefly the symptoms experienced.	4. Was a third party involved? ☐ No ☐ Yes (please describe his/her part in this Accident, and state whether reimbursement or other compensation will be provided.)
5. Has this condition been diagnosed or treated previously?	
6. Dates, Names and Addresses of Doctors previously consulted.	

For Dental work

Name and Type of Procedure:	Please specify the corresponding tooth numbers treated.

AIG

Patient Name: _____ Policyholder Number: _____

DECLARATION AND CONSENT CLAUSE

Consent

I, HEREBY DECLARE that to the best of my knowledge and belief, the above particulars as declared by me above are true and complete in every respect and are made without reservation of any kind.

In relation to the personal information collected in this claim form (or otherwise provided during the course of the claim process, including by way of call recordings), I agree and consent, and if I am submitting information relating to another individual, I represent and warrant that I have the authority to provide that information to AIG Asia Pacific Insurance Pte. Ltd. ("AIG") and/or its service providers, I have informed the individual about the purposes for which his/her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by AIG and/or its service providers, as set out in the contents of the consent clause below and the individual agrees and consents, that AIG and/or its service providers may collect, use and process my/his/her personal information as follows:

(a) the personal information may be collected, used and disclosed by AIG and/or its service providers to:

(i) process and administer this insurance claim;
(ii) assess, investigate, adjust and make a decision on this claim;
(iii) administer my insurance policy (including pursuing recovery from reinsurers or other parties);
(iv) deal with disputes and complaints,
(v) respond to requests for information from public and governmental/ regulatory authorities, statutory boards and for audit, compliance, investigation and inspection purposes;
(vi) respond to requests from the policyholder;
(vii) carry out due diligence or other screening activities (including background check(s)) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by AIG;
(viii) compliance with legal or regulatory obligations, risk management procedures and AIG internal policies;
(ix) manage AIG's infrastructure and business operations; and
(x) for other purposes stated in AIG's Data Privacy Policy.

(b) AIG and/or its service providers may transfer the personal information to the following classes of persons (whether located in Singapore or elsewhere) for the purposes identified in (a) above:

(i) third parties providing services related to the administration of my policy (including reinsurers) and processing of my claim;
(ii) AIG's agents;
(iii) brokers, my authorised agents or representatives or next-of-kin;
(iv) the policyholder;
(v) legal process participants and their advisors;
(vi) governmental/regulatory authorities, industry associations, courts, other alternative dispute resolution forums;
(vii) other financial institutions for the purpose of administering this claim, obtaining policy payments;
(viii) loss adjustors, assessors, third party administrators, emergency providers, legal services providers, retailers, medical providers and travel carriers, external auditors;
(ix) another member of the AIG group (for all of the purposes stated in (a)) in any country; or
(x) other parties referred to in AIG's Data Privacy Policy for the purposes stated therein.

Note: The full version of AIG's Data Privacy Policy can be found at http://www.aig.com.sg/sg-privacy_1030_237853.html.

Declaration

I hereby declare that all information provided on this form and the documents submitted herewith is true and correct to the best of my knowledge and belief. The amounts claimed are the actual charges incurred by me, are legally due to me under the terms of this policy, and are not recoverable from any other source.

Authorisation for Release of Information

I authorise any doctor, hospital, or other health provider or facility, insuring or reinsuring company, or employer to release to AIG Asia Pacific Insurance Pte. Ltd. ("the Company") any information or records they may have regarding my health, tests or treatments I have received, benefits or compensation therefore. If this claim relates to an accident, past or present, I also authorise any governmental body, agency, or other person or organisation who may have records pertaining to such accident to release such records or information.

I understand that this information will be used by the Company to determine eligibility for benefits, and that any information obtained will not be released by the Company to any person except to reinsuring companies or other persons or organisation(s) performing business or legal services in connection with my claim, save as may be required by law. I agree that a photocopy or facsimile of this release shall be as effective as the original.

Name of Policyholder	Signature of Policyholder (parent/guardian if a minor)	Date

SECTION C

To be answered by the Attending Physician

Patient Name: _____ Identity Card Number: _____

1. Describe briefly the patient's medical condition or injury (if due to an accident).

2. When did the patient first consult you for this condition?

3. What were the symptoms experienced by the patient prior to consulting you?

4. How long has the patient been experiencing these symptoms prior to consulting you?

5a. What is your diagnosis of the patient's condition?

5b. International Classification of Diseases (ICD) 10 Code (Mandatory Field)

6. What is the underlying cause of the condition being treated?

7. Have you treated the patient previously for a similar or related condition?
Please provide a brief history including dates and details of treatment given below.

Date: Treatment:

8. Has the patient been treated previously by another physician for a similar or related condition?
Please provide dates and details of treatment and physicians consulted below.

Date: Treatment: Doctors Consulted: Address:

9. Please provide copies of the patient's referral letter, results and interpretation of laboratory tests and diagnostic procedures conducted.

10. Where Surgery was involved, please provide details and dates of surgical procedure (s), and a copy of the operation notes, pathology report and discharge summary.

11. What is your prognosis of the patient's condition and future treatment plans?

12. Is this condition due to an accident, work related injury or arising out of the duties of employment? Please explain.

13. Where treatment is related to any of the following conditions, please underline the condition: birth defect, congenital condition, fertility/ assisted conception, contraception, psychiatric/psychological/mental/nervous condition, behavioral disorders, developmental abnormalities, cosmetic treatment.

14. Claims involving pregnancy. Please state approximate commencement date of last menstrual period.

To be answered by the Attending Physician

Name: _____

Address: _____

City: _____ Postal Code: _____ Country: _____

_____ _____

Physician's Signature / Clinic Stamp Date

IMPORTANT

☐ Have you completed Sections A and B?

☐ Have you signed the Declaration and Authorisation for Release of Information?

☐ Have you enclosed all original bills, statements, receipts, and other documents?

☐ If required, has your physician completed and signed Section C?

This form must be completed truthfully and accurately.

The list of documents required is not exhaustive and we reserve our right to request from you any additional information/documentation, as necessary. The submission of an incomplete form or insufficient information or supporting documents may delay the processing or result in the denial of your claim.

The completed form should be returned together with all supporting documents as soon as possible to the following address:

Henner - GMC Services Asia Pacific Pte Ltd
137 Telok Ayer Street #07-01/02/03 Singapore 068602

Hotline: +65 6751 5271
Fax: +65 6751 5047
Email: aig.apac@henner.com
Administrator Website: www.henner.com/aig/apac

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