redefining / standards

AXA Affin General Insurance Berhad (23820-W)
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Statement of Claim

You are to disclose to us, fully and faithfully all the facts which you know or ought to know, otherwise the claim submitted hereunder may be declined.

We are committed to protect the personal data submitted by and collected from you. For further details, please refer to our "Data Privacy Notice" published in our website.

A. DETAILS OF INSURED

1. Company's Name (if applicable):	
2. Name of Insured Person/Employee:	
3. NRIC/Passport No.:	4. Contact No.:
5. Policy No.:	6. Email:

B. DETAILS OF CLAIMANT/PATIENT

1. Name of Claimant/Patient:		
2. NRIC/Passport/Birth Cert. No.:		3. Contact No.:
4. Claimant is: ☐ Self ☐ Spouse ☐ Child	5. Marital status:	6. Occupation:
7. Employer and address:		

C. ACCIDENT (Please complete if applicable)

1. Date: dd/mm/yy	2. Time: am/pm	3. Place:	4. At work: Yes ☐ No ☐
5. State how it happened:			
6. Nature and extent of injury sustained:			

D. SICKNESS (Please complete if applicable)

1. Nature of illness:	
2. Date symptoms first began: dd/mm/yy	3. Date first treated: dd/mm/yy
4. Has this condition been treated previously? Yes ☐ No ☐ (If yes, please provide doctor's name, contact number and address)	

E. OTHER INFORMATION (Must be fully completed)

1. Give details of other health/medical insurance cover (if any):

2. Claim payment in favour of? (Please specify the name of Payee)

☐ Policyholder/Employer _____

☐ Insured Person/Employee/claimant _____

F. INSURED'S BANK DETAILS

Name (as per bank account):	NRIC/Passport/Birth Cert. No.:
Bank Account No.:	Email:
Name of Bank:	Bank SWIFT Code:
Bank Branch/Address:	

G. CLAIMANT'S DECLARATION/AUTHORISATION TO RELEASE INFORMATION

I confirm I am the patient, patient's parent or guardian (wherever applicable) and wish to claim and declare that all the particulars given above are to the best of my knowledge true and correct. I hereby authorise any physician, hospital, clinic, insurance company or any organisation, institutions or person to give full particulars about my/the patient's (wherever applicable) health policy details, whole medical history and billing information to AXA Affin General Insurance Berhad. I further consent to the disclosure of all such medical information & records by AXA Affin General Insurance Berhad to any insurers, re-insurers, solicitors, my employer, agents/brokers & 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 Person/Claimant: Name: Date: dd/mm/yy

H. TO BE COMPLETED BY EMPLOYER (Please complete if applicable)

Signature of Employer	Date	Company's Name and Stamp
	dd/mm/yy	

I. 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.

1. Name of patient:

2. NRIC/Passport/Birth Certificate No.: | 3.Sex: | 4. Age:

5. Name of hospital:

6. Date and time of admission: dd/mm/yy am/pm | 7. Date and time of discharge: dd/mm/yy am/pm

8. Reason for admission/symptoms:

9. Vital signs: Temperature: _____ Pulse: _____ TPR: _____ BP _____

10. Provisional diagnosis: | 11. Date you were first consulted: dd/mm/yy

12. Have you seen this patient before for other problems? Yes ☐ No ☐
(If yes, please give date and type of problem)

13. Was this patient referred to you? Yes ☐ No ☐
(If yes, please provide doctor's name and address or the referral letter)

14. Has the patient ever had the same or similar condition or being informed of this condition before? Yes ☐ No ☐
(If yes, please state when)

15. Name and address of doctors previously consulted by the patient for the condition:

16. How long in your professional opinion has the condition existed? _____ days _____ months _____ years

17. Final diagnosis/ICD Coding:

18. Cause and pathology (if applicable) for the above diagnosis:

19. Type of investigation and result:

20. Is this admission primarily for investigation? Yes ☐ No ☐

21. Treatment required:

22. Please state type of procedure performed:

Procedure type	Name of doctor	Reason for procedure done
(i)		
(ii)		

23. Other medical conditions or underlying disease present?

Medical condition	Since (dd/mm/yy)
(i)	
(ii)	

24. Insured's past medical history (if any):

25. Was the condition related to:

(a) Congenital/Hereditary ☐ Yes ☐ No
(b) Anxiety/Mental disorder ☐ Yes ☐ No
(c) Self-inflicted/Drugs or Alcohol abuse ☐ Yes ☐ No
(d) STD/AIDS/HIV ☐ Yes ☐ No
(e) Pregnancy/Childbirth or Infertility ☐ Yes ☐ No
(f) Cosmetic/Plastic surgery ☐ Yes ☐ No
(g) Routine health screening ☐ Yes ☐ No

26. Can this sickness or injury be treated as an:

(a) Outpatient basis? ☐ Yes ☐ No
(b) Day surgery basis? ☐ Yes ☐ No
(If no, please provide details)

27. Was the patient pregnant at the time of the hospitalisation? (For female patient only) ☐ Yes _____ months ☐ No

28. Any possibility of a relapse? ☐ Yes ☐ No | 29. Is follow-up required? ☐ Yes ☐ No

30. If the hospitalisation was due to accident, please indicate:

Date: dd/mm/yy Time: am/pm

Nature of accident: Extent of injury:

31. Medication on discharge:

I hereby certify that the answers above are full, complete and true.

Date: dd/mm/yy Signature, name and address of physician: