AVIVA

CGU International Insurance plc
Claims Department (Group Life, Accident & Health)
4 Shenton Way, #23-01 SGX Centre 2, Singapore 068807
Tel: (65) 6827 7888 Fax: (65) 6827 7705

HEALTHCARE MEDICAL CLAIM FORM

The Insured Member is required to furnish the following documents to **CGU or through the insurance broker**

1) Complete the following Claim Form.
2) Attach **originals** of all relevant documents and final detailed hospital doctor's bills and receipts.
3) Your doctor must complete and sign Section III of this Claim Form.
4) Use a new Claim Form for each separate claim or illness.
5) Section II of the Claim Form is for Group Clients only. Please state the name of payee clearly under Item 2.
6) The Company would reimburse the policyholder the amount which is payable under the policy. If Medisave is used, the appropriate amount would be credited into the respective Medisave account.

POLICY NO. _______________

SECTION I: TO BE COMPLETED BY INSURED MEMBER

1) Name of Insured Member	NRIC /Passport No.	Occupation	Marital Status	Date of Birth	Sex
2) Name of Patient (If other than Insured Member)	NRIC/Passport No.	Occupation	Marital Status	Date of Birth	Sex

3) Present Address	4) Contact No.

5) Is the Insured Member / Patient presently also insured for medical under another Insurance Company? ☐ Yes ☐ No

If "Yes", (a) Name of Insurance Company: _______________ (b) Policy No. : _______________

DETAILS OF ILLNESS / ACCIDENT

6) Sickness	a) Nature of Illness/Final Diagnosis	b) Date First Treated	c) Nature of Treatment/Operation
7) Accident	a) Time and Date of Accident	b) Date First Treated	c) Describe How Accident Happened

8) Attending Doctor's Name and Address

I hereby authorise any hospital, physician, person or organisation to disclose all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records. A photostat copy of this authorisation shall be considered as effective and valid as the original.

I certify that the above statements and answers are true and complete to the best of my knowledge and belief.

Signature of Insured Member _______________ Signature of Patient _______________ Date _______________

SECTION II: TO BE COMPLETED BY EMPLOYER/POLICYHOLDER (NOTE: THIS SECTION IS FOR COMPLETION BY GROUP CLIENTS ONLY)

1) Name of Employer / Policyholder _______________

2) Please state the name of payee for the cash portion in order for us to effect the payment:
Note: (a) Payee should be the Insured or Insured Person only.
(b) Payee shall not include clinic, physician and any other medical providers.
(c) Please write the payee in capital letters and amount clearly and accurately to avoid any delay in cheque issuance

Name of Payee _______________ Amount _______________

Signature of Employer _______________ Company's Name/Stamp _______________ Date _______________

SECTION III: TO BE COMPLETED BY ATTENDING PHYSICIAN/SURGEON

1) Name of Patient:
NRIC/Passport no:

2) Name of Insured Person's company:

3) Final Diagnosis (Based on ICD, 1975 Revision, WHO) of illness* or extent of injury.

DRG Code	ICD Code	ICD Code
☐☐☐☐	☐☐☐☐	☐☐☐☐

4) What is the cause of the illness/injury?

5) Is the condition/ treatment related to:

		Yes	If yes, please elaborate.	No
a) Pregnancy or childbirth	a)	☐	______	☐
b) Abortion or Miscarriage	b)	☐	______	☐
c) Infertility or Sub-fertility Condition	c)	☐	______	☐
d) Congenital Anomaly	d)	☐	______	☐
e) Genetic or Chromosomal Disorder	e)	☐	______	☐
f) Mental or Psychiatric Condition	f)	☐	______	☐
g) Cosmetic Surgery	g)	☐	______	☐

6) Please specify the approximate date of discovery of the illness or injury.

7) How long has the illness/injury been existing prior to consulting you?

8) Did the patient have any symptoms prior to consulting you?
Yes ☐ If yes, please indicate the nature of Symptoms and date Symptoms first started: No ☐

______

9) When did the patient first consult you for this condition?

10) Nature and Date of Treatment rendered.

11) Has the patient ever had the same or similar condition/symptom?
Yes ☐ No ☐ Not to my knowledge ☐

12) If yes, please indicate when and describe.

13) Doctors previously consulted by the patient for the above condition.

Name	Approximate Date	Name of Clinic	Address

14) Describe the surgical procedures or treatment rendered.
If no surgery was performed, please state treatment/medication given.

15) Date surgical procedures or treatment rendered : ______

Operation Code	Operation Table
☐☐☐☐☐☐	☐☐

16) If excision was performed, please indicate the size of the lesion/tumor.
(Please attach a copy of the Histology Report)

17) Name of
a) Physician ______
b) Surgeon ______
c) Anaesthetist ______

18) Is the surgery done for cosmetic reasons?

19) If no, please explain why surgery was necessary.

20) Is the patient still under your care for this condition?

21) If no, please give date service was terminated, and furnish name and address of doctor if the patient has been referred to another doctor for follow-up.

22) Admission period

23) What is the prognosis of this illness?

*Please tick the appropriate illness classification.

☐ Alimentary system, includes liver & billary tract	☐ Diseases of the nervous system	☐ Metabolic & endocrine disease
☐ Musculo-skeletal system & connective tissue disorder	☐ Cancer/malignant tumour growth	☐ Eye
☐ Haematological disorders/autoimmune disorders	☐ Respiratory System	☐ Female diseases/condition
☐ Diseases of skin and subcutaneous tissue	☐ Cardiovascular system	☐ Infectious diseases
☐ Symptoms, signs and ill-defined conditions	☐ Ear, nose & throat system	☐ Dental/bucco-mucusal
☐ Diseases of genito-urinary system	☐ Psychological/Psychiatric	

______
Signature of Physician/Surgeon

______
Date

______
Name/Designation

______
Name and Address of Clinic/Hospital