



COMBINED CLAIM FORM

TYPE OF CLAIM & CHECKLIST (please select)

<input type="checkbox"/> Hospitalisation & Surgical <input type="checkbox"/> Completed Claim Form <input type="checkbox"/> Original Final Medical Bills & Receipts <input type="checkbox"/> Medical Report/Discharge Summary/Day Surgery Authorisation Form	<input type="checkbox"/> Outpatient GP / A&E <input type="checkbox"/> Completed Claim Form <input type="checkbox"/> Original Medical Bills & Receipts
<input type="checkbox"/> Personal Accident <input type="checkbox"/> Completed Claim Form <input type="checkbox"/> Original Medical Bills & Receipts <input type="checkbox"/> Doctor's Memo providing description injury & treatment (if available) <input type="checkbox"/> Police Report (for traffic accidents)	<input type="checkbox"/> Outpatient Specialist <input type="checkbox"/> Completed Claim Form <input type="checkbox"/> Original Medical Bills & Receipts <input type="checkbox"/> Referral Letter from GP <input type="checkbox"/> Doctor's Memo providing description of condition & treatment (if available)

PEI Name :

Policy Number(s) :

SECTION A DETAILS OF INSURED PERSON (STUDENT)

Name of Insured Student (as per bank account)	Passport No.	Student ID No/FIN No.	Date of Admission to School
Please tick to select status <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part Time Student		Please tick to select status <input type="checkbox"/> Singapore Citizen/PR <input type="checkbox"/> International (non STP) <input type="checkbox"/> International (STP)	
E-mail	Telephone No.	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (in Singapore)		Please settle claim payment by : <input type="checkbox"/> by cheque to student <input type="checkbox"/> by cheque to school	

SECTION B DETAILS OF ILLNESS

1. Nature of Illness/Symptoms/Final Diagnosis	2. Date Symptoms First Noticed		
3. Type of Treatment/Operation	4. Date First Treated	5. Hospitalisation Period	

SECTION C DETAILS OF ACCIDENT

1. Description of Accident (how it happened)	2. Place of Accident	3. Date of Accident	4. Time of Accident
5. Nature of Injury	6. Treatment/ Operation	7. Hospitalisation Period	8. Is this a job-related injury <input type="checkbox"/> No <input type="checkbox"/> Yes

SECTION D OTHER INFORMATION

1. Has the illness been treated before? Has the same part been injured before? <input type="checkbox"/> No <input type="checkbox"/> Yes, please state date first occurred	2. Are you making a claim for this treatment from any other insurance company? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide settlement advice from the insurer
3. Name & Address of Attending Doctor/Clinic/Hospital	

SECTION E DECLARATION, AUTHORISATION & CUSTOMER'S DATA PRIVACY CONSENT

[Declaration] I/We confirm that I am/we are the claimant and/or the Policyholder and I/We declare that all the particulars given above are to the best of my/our knowledge true and correct.

[Authorization] I/We hereby consent to and authorize the medical practitioner involved in the claimant's care to discuss and disclose treatment details and discharge arrangements with and to AXA Insurance Pte Ltd. I/We agree that a copy of this consent shall have the validity of the original.

[Customer's Data Privacy Consent] In connection with my claim, I give consent for AXA Insurance Pte Ltd ("AXA") and their respective representatives or agents to collect, use, store, transfer and/ or disclose the information (including that provided by sources other than myself) concerning me, to or with all such persons (including any member of the AXA Group or any third party service provider, and whether within or outside of Singapore and the Policyholder when claiming under a Group Policy) for the purpose of enabling AXA and their respective representatives or agents to provide me (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/ or managing my claims or the Policyholder Policy with AXA (as the case may be), and for the purposes set out in AXA's Data Use Statement which can be found at <http://www.axa.com.sg> ("Purposes")."

Signature of Insured Student	Date
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TO BE COMPLETED BY SCHOOL/PRIVATE EDUCATION INSTITUTION

Is student registered with PEI on date of accident/illness? <input type="checkbox"/> No <input type="checkbox"/> Yes	Verified and Witnessed by PEI: Sign & Stamp	Name of Authorised Officer (PEI): Designation of Authorised Officer (PEI):
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redefining / insurance

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Co.Reg No. 199903512M

Medical Report
Policy No.

To be completed by your treating doctor if you have attended a private hospital or a hospital outside Singapore

1. Name of Patient

2. NRIC/FIN/Passport No.

3. Date admitted (DD/MM/YYYY) Date discharged (DD/MM/YYYY)

4. Was patient referred to you by another doctor? Yes No

If "Yes", please state date of referral and provide us with the name and address of referring doctor.

Date of Referral (DD/MM/YYYY) Name of Doctor and address of clinic

5. When did patient first consult you for the condition? Date of first consultation (DD/MM/YYYY)

6. What were the complaints or symptoms presented during the first consultation?

7. When did patient first experience these complaints or symptoms? Date of first consultation (DD/MM/YYYY)
If there were no complaints or symptoms, what prompted the patient to see you?

8. In your expert opinion, per history provided to you by patient and given the etiology of the condition, please state the estimated duration of such condition would be in existence for this patient.

9. Has patient received any prior treatment for these complaints or symptoms? Yes No

If "Yes" please state when and provide us with the name and address of doctor who treated patient previously.

10. Principal Diagnosis

Diagnosed Condition(s)	ICD 10 Code	Date of First Diagnosis (DD/MM/YYYY)	Date Patient Informed of Diagnosis (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Other diagnosis(es)

Diagnosed Condition(s)	ICD 10 Code	Date of First Diagnosis (DD/MM/YYYY)	Date Patient Informed of Diagnosis (DD/MM/YYYY)

Note: If there is more than one diagnosis, please advise whether they are related directly to each other. If yes, please provide us with details to your answer.

Yes No

11. What was the underlying cause(s) of the diagnosed condition(s) as stated in Question 10?

12. Did patient suffer or is suffering from any other co-morbidity (ies) that is/are related to diagnosed condition(s)?

Yes No If 'Yes', please specify

Co-morbidity(ies)	Date of treatment	Name and address of doctor

13. Was surgery performed for the diagnosed condition(s)?

Yes No If 'Yes', please specify

Date of Surgery	TOSP Code	Table	Description

14. If 2 or more surgeries were performed, please specify whether they were done through same incision.

15. If no surgery was performed, please state treatment and medication given.

If patient was admitted for a maternity condition, please complete this section

16. a) Patient's LMP (DD/MM/YYYY)

b) Is the pregnancy a result of any infertility treatment including infertility medication or conception by artificial means?

Yes No If "Yes", please provide details to your answer

c) Type of delivery Vaginal Delivery Elective Caesarean Section Emergency Caesarean Section

If Emergency Caesarean Section, please advise reason(s)

d) Did any complications arise during pregnancy? Yes No If 'Yes', please provide details to your answer

If patient was admitted for miscarriage, please complete this section

17. Was it due to an accident? Yes No

If yes, please describe how it happened?

If no, please state the cause of the miscarriage?

If patient was admitted due to an accident, please complete this section

18. Was the treatment related to accident? Yes No

Date of accident (DD/MM/YYYY)

Road traffic accident Work related accident Others If 'Others', please specify

Please describe how it happened?

Was patient's diagnosed condition(s)/ surgery(ies)/ treatment due to or related to any of the following

19. Dental condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	A psychiatric condition	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abortion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol Dependence/Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infertility/Sub-fertility/ Impotence/ Contraception/ Sterilisation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnoea/Sleep Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Self-inflicted injury/Attempted Suicide	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sexually transmitted disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Refractive error of the eye(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS or HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity/ Weight Reduction/Weight Improvement	<input type="checkbox"/> Yes <input type="checkbox"/> No
A congenital condition	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Learning disorder/Behavioural problem/Physical & Psychological development problem			<input type="checkbox"/> Yes <input type="checkbox"/> No

20. Was the treatment a/ an

Experimental medical treatment Cosmetic/ Plastic surgery

If you have ticked any boxes, please give details of the treatment(s)/surgery(ies).

21. Any other information that may assist us in the assessment of the claim.

I hereby certify that I have personally examined and treated the patient in connection to the above condition(s) and the facts as given above represent my opinion of his/ her condition. I declare and agree to make the declaration on this claim form.

Signature of Doctor

Date

Name of Doctor

Hospital/Clinic stamp