International Exclusive

Medical Claim Form

Please complete this form in full in order to assure a fast and accurately processing.
All fields are compulsory. We will not be able to process for incomplete form.
This claim form is not an admission of liability.

PART 1 - ADMINISTRATIVE (Part 1 to be completed by policyholder)	
POLICYHOLDER:	POLICY NUMBER:
EMAIL ADDRESS:	EMAIL ADDRESS:
PATIENT/INSURED PERSON'S DETAILS	
PATIENT/INSURED PERSON'S NAME:	DATE OF BIRTH (DD/MM/YYYY):
ID/ PASSPORT NUMBER:	GENDER: ☐ Male ☐ Female
EMAIL ADDERSS:	CONTACT NUMBER:
PLAN:	
FOR GROUP POLICYHOLDERS ONLY	
NAME OF EMPLOYER:	INSURED PERSON'S OCCUPATION:
DATE JOINED EMPLOYER (DD/MM/YYYY):	NAME OF AUTHORIZED OFFICER:

PART 2 - MEDICAL DETAILS

Was there any previous consultation/treatment/hospitalization for this condition and/or associated conditions or symptoms, in this hospital or any other facilities (for example but not limited to clinic, TCM, alternative practitioner etc)?

☐ Yes ☐ No **If Yes, please provide details below:**

DATE (DD/MM/YYYY):	DISEASE/DISORDER (Details of treatment/consultation):	NAME OF DOCTOR & HOSPITAL/FACILITY:	CONTACT ADDRESS & TELEPHONE DETAILS:

Please provide details of your or patient's regular doctor(s)/company doctors(s)/other doctors below if any.

DATE (DD/MM/YYYY):	DISEASE/DISORDER (Details of treatment/consultation):	NAME OF DOCTOR & HOSPITAL/FACILITY:	CONTACT ADDRESS & TELEPHONE DETAILS:

2.1 ARE YOU CLAIMING CASH SUBSIDIES?	☐ Yes	☐ No
2.2 ARE YOU CLAIMING PUBLIC HOSPITAL ALLOWANCE?	☐ Yes	☐ No
If you are claiming for treatment received outside your area of cover, please answer the following questions:		
2.3 COUNTRY WHERE THE TREATMENT TOOK PLACE:		
2.4 THE REASON FOR BEING ABROAD:		
DATE OF DEPARTURE AND RETURN TO OWN AREA OF COVER (DD/MM/YYYY):	From:	To:

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PART 3 - OTHER DETAILS

3.1 IS THIS TREATMENT COVERED UNDER ANOTHER INSURANCE POLICY ?
(If you have answered 'Yes', please give the name of the related insurance company involved and a copy of the other insurance company's claim settlement letter/payment voucher.)

☐ Yes ☐ No

If yes, _____

3.2 IS THIS TREATMENT RELATED TO ACCIDENT ?
(If you have answered 'Yes', please give details of the accident.)

☐ Yes ☐ No

If yes, _____

PART 4 - MEDICAL SECTION (Part 4 to be completed by medical practitioner)

SYMPTOMS PRESENTED:	Date the patient first became aware of any signs or symptoms for this condition (DD/MM/YYYY):	Date on which the patient first presented to any doctor for this condition (DD/MM/YYYY):

MEDICAL CONDITION/DIAGNOSIS:

INVESTIGATION (Describe necessary investigations requested/required to define the diagnosis):

FURTHER TREATMENT PLAN:

IF CLAIM IS RELATED TO PREGNANCY, IS PREGNANCY CONCEIVED FROM NATURAL CONCEPTION ? ☐ Yes ☐ No

DATE OF ADMISSION & DISCHARGE (APPLICABLE TO HOSPITALIZATION ONLY) (DD/MM/YYYY):

TREATMENT ADVISED (Applicable for pre-authorization only)

ADMITTING HOSPITAL:	DATE OF TREATMENT:
TREATMENT PLAN:	ESTIMATED LENGTH OF TREATMENT (IN DAYS):
Room type: Room charge per night: Total estimated room & all hospital charges:	Estimated cost for treating doctor (i+ii): I. Daily visit estimate cost: ii. Surgery estimate cost: Estimated cost for anesthetist: Total estimated cost for treating doctor/surgeon and anesthetist:

MEDICAL PRACTITIONER'S DECLARATION

I declare that I am the patient's medical practitioner, and that the particulars given are true and correct to the best of my knowledge.

NAME:	CONTACT NUMBER:	DATE (DD/MM/YYYY):
HOSPITAL/CLINIC STAMP:	SIGNATURE:	

If you are not satisfied with the settlement result of your medical expenses and your claim appeal has not been effectively resolved through our hotline or customer service email, you can contact us at **claims-appeal@axatp.com**. We will initiate the claim appeal review process for you. After receiving your appeal, the claim appeal team will review it as soon as possible and reply within 10 working days.

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PART 5 - DECLARATION AND AUTHORIZATION BY THE POLICYHOLDER

I hereby declare and authorize:

5.1 That I authorize the medical practitioner, Hospital/Clinic or any other medical institution to give the information and/or medical record, according to the diagnosis and/or medication treatment which is/has been given to me or my family member who being as the insured.

5.2 That I authorize AXA Tianping Property & Casualty Insurance Co., LTD. and its designated third party administrators to gather further information/medical records from the Hospital and or other parties related to the diagnosis and or health services provided to me or my family member which may be required to process the claim in accordance with existing policy and term conditions.

5.3 That all information on this hospital admission/pre-authorization claim form (In-patient) is written truthfully and I hereby agree that this Letter of Authority to be used promptly.

5.4 That copy of this Declaration is as valid and has power in accordance with the original document.

5.5 That the approval (where applicable) of this claim does not discharge my obligations to fulfill the terms and conditions under the policy which I and/or family member is/are insured, and also, AXA Tianping Property & Casualty Insurance Co., LTD. is not obliged to pay the ongoing costs of continuing, or similar, treatment, even where AXA Tianping Property & Casualty Insurance Co., LTD. has previously paid for this type of, or similar treatment, if it is subsequently noted that this claim is not an eligible treatment.

5.6 I authorize my Financial Advisor/Broker/Agent to discuss medical conditions as necessary with my insurer or its authorized agent on my behalf.

☐ Please tick the box if you do not authorize your financial Advisor/Broker/Agent to discuss medical conditions with the insurer or its authorized agent on your behalf.

5.7 I consent to AXA Tianping P&C Insurance Co., Ltd. (Hereinafter referred to as AXA TP) providing my personal information to overseas recipients within the following scope.

Name of overseas recipient	Contact information	Purpose of processing	Method of processing	Category of personal information	The methods and procedures for exercising your rights to overseas recipients
AXA Life and Health Reinsurance Solutions PTE. LTD.	Enquiries.ALHRS @axa.com	For the case beyond the claim authority of AXA TP, the detailed data of the claims of the case shall be provided to the designated overseas management organization of AXA (the overseas recipients listed in this form) for application and approval.	Data approval	The personal information contained in the "Section 6 - Required Claim Documents" of this claim application form.	You can contact overseas recipients through the provided contact information in this form.
AXA Global Healthcare (UK) Limited	+44 (0)1892 503 856				

POLICYHOLDER SIGNATURE:	**DATE** (DD/MM/YYYY)**:**	
NAME OF INSURED/POLICYHOLDER:	**ID/PP NO. OF INSURED/POLICYHOLDER:**	**RELATIONSHIP:**
SIGNATURE OF INSURED/POLICYHOLDER:	**MAILING ADDRESS:**	**CONTACT NUMBER:**
NAME OF FINANCIAL ADVISOR/AGENT:	**CONTACT NUMBER:**	

PART 6 - THE FOLLOWING DOCUMENTS MUST ACCOMPANY THE CLAIM DURING SUBMISSION

- ☐ **Claim form which is to be completed fully (Original)**
- ☐ **Original payment receipt (Original/Certified copy) with cost breakdown details**
- ☐ **Results of the diagnostic test/s (Laboratory result, X-Ray, etc-Original/Certified copy)**
- ☐ **Prescription (Original/Certified copy)**
- ☐ **Hospital discharge note (If applicable)**
- ☐ **Insured's ID Copy**
- ☐ **If you are a minor, please provide proof of relationship (birth certificate or household registration book relationship page).**

PART 7 - REIMBURSEMENT OF CLAIMS

AMOUNT CLAIMED:	
TELEGRAPHIC BANK TRANSFER. The account holder must be the Policyholder/Insured.	
NAME OF ACCOUNT HOLDER:	**BANK SWIFT CODE:**
BANK ACCOUNT NUMBER:	**BANK BRANCH:**
NAME OF BANK:	**BANK ADDRESS:**

If you have any questions regarding this form or any other aspects of the coverage, please contact our Health Service Team at 400 685 0802(or +86 21 6187 0233 for overseas call) quoting you membership card no.
Claims must be submitted along with all supporting documents.
Send this claim form together with all supporting documents to :
Recipient: High-end Medical Service Team
5F, Building 9, Lujiazui Software Park, Lane 91 E Shan Road, Pudong, Shanghai, P.R.C 200127

WECHAT OFFICIAL ACCOUNT
微信公众号

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