

**AXA INSURANCE SINGAPORE PTE LTD**  
 143 Cecil Street #01-01 GB Building  
 Singapore 069542  
 Tel: (65) 6338 7288 Fax: (65) 6338 2522 [www.axa.com.sg](http://www.axa.com.sg)



**COMBINED CLAIM FORM**

**Please send claim form and documents to:**  
**AEGIS INSURANCE SERVICES PTE LTD**  
 15 Queen Street, #03-07 Tan Chong Tower  
 Singapore 188537  
 Tel: (65) 6837 0306 Fax: (65) 6837 0305  
 Email: [customerservice@aeqisic.com](mailto:customerservice@aeqisic.com)  
[www.aeqisic.com](http://www.aeqisic.com)

**Please complete this claim form fully.**  
**Incomplete forms may delay claim settlement.**

**TYPE OF CLAIM & CHECKLIST (please select)**

<input type="checkbox"/> <b>Hospitalisation &amp; Surgical</b> <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"/> <b>Outpatient GP/A&amp;E</b> <input type="checkbox"/> Completed Claim Form <input type="checkbox"/> Original Medical Bills & Receipts
<input type="checkbox"/> <b>Personal Accident</b> <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"/> <b>Outpatient Specialist</b> <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)

<b>PEI Name :</b>	<b>Policy Number(s) :</b>
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**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"/> credit to student's bank* <input type="checkbox"/> by cheque to student <input type="checkbox"/> others _____ (*for outpatient claims only if applicable)		

**SECTION B DETAILS OF STUDENT'S BANK ACCOUNT - Please complete if you tick claim payment by credit to student's bank (For Outpatient claims only)**

Bank Name (please tick) <input type="checkbox"/> DBS/POSB <input type="checkbox"/> UOB <input type="checkbox"/> OCBC <input type="checkbox"/> others	Branch	Account No. 
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**SECTION C 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 D 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 E 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 state name of insurer
3. Name & Address of Attending Doctor/Clinic/Hospital	

**SECTION F DECLARATION & AUTHORISATION**

I hereby authorise any hospital, physician, person or organisation who has attended to or examined me, or is authorized to maintain medical records, to disclose when requested to do so by AXA Insurance Singapore Pte Ltd any and all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.  
 I hereby declare that the above information, statements answers are true and complete to the best of my knowledge and belief. I agree that if I have made, or if I shall make, any false or untrue statement, suppression or concealment, the Policy shall be void and all rights to compensation shall be absolutely forfeited.

<b>Signature of Insured Student</b>	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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