



Nexus Risk Management
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AIG GlobalHealth Plan
MEDICAL CLAIM FORM

Important Notice

- a) Please complete **Section A (this page)** for all claims and ensure that details of any treatment, investigations or procedures are indicated in the table below. Please furnish us the supporting test reports and any other relevant documents.
- b) Please have your Physician fill out **Section B (on the reverse page)** if your claim involves any of the following:
 - **Maternity (For the first submission of claim only)**
 - **Day surgery**
 - **Specialist consultation**
 - **Inpatient / Hospitalisation**
 - **Any diagnostic tests**
 - **Upon request of the company**

Policy/Member Information

Name of Patient : _____
 Identity Card /Passport No.: _____
 Name of Policyholder : _____
 Policy Number : _____
 Member Number: _____

Contact Details (if different from policy)

Send settlement to this address? : Yes
 Address: _____
 Country: _____
 Telephone: _____ (H) _____ (O)
 Facsimile : _____
 E-mail Address : _____

Please pay claims in the selected currency :

SG\$ US\$

Section A

Illness Details

Nature of Illness : _____

 When did symptoms/illness first start?

 If you have had previous similar complaints, when?

Accident Details (if due to an accident)

Nature of Injury : _____
 Date and Time of Accident : _____
 How did the Accident happen? _____

 Was a 3rd party involved? Yes No
 If "yes", state whether reimbursement or other compensation will be provided.

Details of Invoices (you are to submit all original detailed invoices)

Name of Clinic/Medical Provider	Date of Consultation	Reason for Consultation	Total Amt. Incurred	Breakdown of Services and Charges (e.g. medication, tests, consultation etc.)	Type of Medication

Please use separate insert for the above if necessary.

Declaration

I hereby declare that all information provided on this form and the documents submitted herewith is true and correct to the best of my knowledge and belief. The amounts claimed are the actual charges incurred by me, are legally due to me under the terms of this policy, and are not recoverable from any other source.

Authorization for Release of Information

I authorize any doctor, hospital or other health provider or facility, insuring or reinsuring company, or employer to release to the Insurer ("the Company") any information or records they may have regarding my health, tests or treatments I have received, and benefits or compensation therefore. If this claim relates to an accident, past or present, I also authorize any governmental body, agency or other person or organization who may have records pertaining to such accident to release such records or information. I understand that this information will be used by the Company to determine eligibility for benefits, and that any information obtained will not be released by the Company to any person except to reinsuring companies or other persons or organization(s) performing business or legal services in connection with my claim, save as may be required by law. I agree that a photocopy or facsimile of this release shall be as effective as the original.

Signature of Member : _____
 (to be signed by parent if member is a minor)

Date : _____

Section B (Attending Physician to complete at Insured Person's expense)

1. Name of Patient: _____
2. On what date did the patient first consult you for the condition? _____
3. a. What were the signs or symptoms experienced by the patient prior to consulting you? _____
- _____
- b. How long had the patient been experiencing the symptoms prior to consulting you? _____
4. Has the patient ever been treated for this condition before? No Yes
If yes, please indicate when, name and address of doctor treating the patient. _____
- _____

5. Was the patient referred to you by any doctor? No Yes
If yes, please state the name and address of referring doctor. _____
- _____

6. a. What was the diagnosis? _____ ICD 9 Code:

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- b. When was this condition diagnosed? _____

7. Is the condition/ treatment related to:

Pregnancy / childbirth	: <input type="checkbox"/> No <input type="checkbox"/> Yes	Psychiatric / mental / nervous condition	: <input type="checkbox"/> No <input type="checkbox"/> Yes
Congenital anomaly	: <input type="checkbox"/> No <input type="checkbox"/> Yes	Behavioral / developmental disorder	: <input type="checkbox"/> No <input type="checkbox"/> Yes
Cosmetic / reconstructive surgery	: <input type="checkbox"/> No <input type="checkbox"/> Yes	Venereal disease / HIV	: <input type="checkbox"/> No <input type="checkbox"/> Yes
Infertility / IVF treatment	: <input type="checkbox"/> No <input type="checkbox"/> Yes	Self-inflicted injury	: <input type="checkbox"/> No <input type="checkbox"/> Yes
		General health-screen	: <input type="checkbox"/> No <input type="checkbox"/> Yes

If yes, please elaborate: _____

8. a. Is this condition related to any accident or injury? No Yes
b. Is this condition related to any work related illness or accident? No Yes
If yes to any of the above, please provide the date of accident and explain the extent of injury sustained. _____
- _____

9. Please provide copies of full medical reports including but not limited to past medical history, referral letters, investigative procedures and treatments. Attached

10. **(Claims for Surgery)** In addition to information (9) above, please provide the following:
- a. Name and date of surgical procedure(s) _____
- b. Copies of operation notes, pathology reports and discharge summary. Attached

11. Please advise the future treatment plan for this patient's condition. _____
- _____

12. **(Claims for Pregnancy)** Please furnish copies of the antenatal screening reports and state:
- a. Date of Last Menstrual Period (LMP): _____
- b. Estimated Date of Delivery (EDD): _____

I hereby certify that the facts given above are true to the best of my knowledge.

Name & Address of Attending Physician: _____ Physician's Signature: _____ Qualifications: _____

Date: _____

Important Note (to Claimant) :

- Have you completed **Section A**?
- Have you signed the Declaration and Authorization for Release of Information?
- Have you enclosed all original bills, statements, receipts and all relevant documents?
- If required, has your Physician completed and signed **Section B**?
- Please contact us if you have questions on how to submit your claim.

Please send completed form and all original bills, statements, receipts and all relevant documents to :

GlobalHealth Asia Pte Ltd
133 New Bridge Road #17-03 Chinatown Point, Singapore 059413
Telephone: +65 6557 0896 Facsimile: +65 6557 0796

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