HOSPITALIZATION CLAIM FORM

((Filled by Policy Holder / Insured)

To fasten the claim process, please filled all the questions below correctly, completely and briefly.

I who signed the form :

Data of Policy Holder & Insured

Name of Policy Holder : _____

Name of Insured : _____

Policy Number : _____

Phone Number/Handphone : _____ ID Number : _____

Stated that :

Data of Patient

Name of Patient : _____ Gender : ☐ Male ☐ Female

Nick name/another name : _____

Place, Date of Birth; Age : _____ , _____ ; _____ years

ID Number : _____

Has been hospitalized :	
Hospitalization period	From (date/month/year) _____ to (date/month/year) _____
Name & Address of Hospital	_____
Doctor	_____
Patient Card No.	_____
If hospitalization due to disease	
Symptoms & signs caused to hospitalization	_____
Since when symptoms and signs first occurred	Date/ month / year : ☐☐ ☐☐ ☐☐☐☐ or since _____
Name/Diagnosis of disease	_____
If hospitalization due to accident	
Place & Date of accident	_____, ☐☐ ☐☐ ☐☐☐☐ date / month / year
Details of injury condition	_____
Chronology of the accident *	_____
If hospitalization due to others cause	
Was hospitalization due to effect of alcohol/narcotic/drugs/others ?	☐ YES ☐ NO Please explain* : _____
Do you have disease history related with Hypertension, Diabetes Mellitus, Heart Disease, Lung Disease, Mentally illness, Congenital, HIV, or other diseases ?	☐ YES ☐ NO If Yes, Disease : _____ Suffered since: _____
Name of Doctor/Hospital/Puskesmas/Laboratorium/others Medical Institution that had been visited for others disease consultation ?	_____
Other policies owned by Insured	Name of Insurance Company : _____ Name of Insurance program : _____ Policy number : _____ Policy effective date : _____

If claim approved, the payment of claim will be transferred to :

Name : _____

Account Number : _____ Currency : ☐ IDR ☐ US$

Bank : _____

Branch Office : _____

Bank's Address : _____

*Please use additional paper if needed

PT. AXA Mandiri Financial Services

Customer Care Center

Axa Tower lt GF Jl Prof Dr Satrio Kav 18 Kuningan City, Jakarta 12940 Indonesia

Telp: +62 21 3005 8788 / Fax : +62 21 3005 7800 / Email : customer@axa-mandiri.co.id

Head Office

Axa Tower lt GF Jl Prof Dr Satrio Kav 18 Kuningan City, Jakarta 12940 Indonesia

Telp: +62 21 3005 8888 / Fax : +62 21 3005 8500 / website : www.axa-mandiri.co.id/life

HOSPITALIZATION CLAIM FORM

STATEMENT AND AUTHORIZATION LETTER

I hereby declare that I had read, understood and answered the questions above completely and correctly. Herewith I give the unlimited authorization due to point 1813 of KUH Perdata to all Doctors, Clinic, Hospital, Puskesmas, Laboratorium, Other's Medical Institution, Insurance Company, Law Institution or Personal who know or have the detail of Patient's condition/health information, to give information to PT AXA Mandiri Financial Services or them who have the authorized given. The copy of this statement has the same legal as the original one.

Signed at _____ Date _____ / _____ / _____

(_____)
Signature and Full Name

Hospitalization Claim should be accompanied with documents as below :

- ☐ Hospitalization Claim Form - **Original**
- ☐ Form of Doctor Statement for Hospitalization Claim - **Original**
- ☐ Receipt/ Invoice from hospital and payment's detail - **Original/Legalized**
- ☐ Supporting examination results (Laboratorium, Radiology, EKG, etc) - **Copy**
- ☐ Other supporting documents

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