CLAIM FORM OUTPATIENT

PT AIA FINANCIAL is a leading life insurance firm registered and supervised by Financial Service Authority

INSTRUCTIONS

1. This Claim Form is applicable for one patient only and must be completed and signed by the Insured/ Participant and/or Policy Holder or if the patient is a minor it must be completed and signed by the Insured/Participant and/or Policy Holder in the capacity of parent or the Attending Physician. For incomplete form, it shall be returned and no claim process shall proceed.
2. Documents that must be attached to this Claim Form shall include:
   a. Original receipts and the breakdowns.
   b. Details of drugs, copies of physician's prescriptions and details of drug prices.
   c. Physician's referral letter and copies of laboratory examinations, Radiology, CT Scan and other supporting checkups.
   d. For Physiotherapy, attach physician's referral letter and the schedule and frequency of therapy.
   e. For Glasses and Lenses, attach the dimensions of glasses/lenses taken from eye examination.

PART. 1 FILLED BY THE CLAIMANT

Policy No :

Participant No :

Gender: ☐ Male ☐ Female

Name of the Insured/Patient :

Date of Birth: (dd/mm/yyyy)

Name of Participant:

ID Card/Passport/Driv. License):

Type of Claim (Choose 1): ☐ Outpatient ☐ Dental ☐ Optic

If the reason is accident, please specify the date when did such accident occur? (DD/MM/YY) and the chronology of the incident (including time and location of the incident).

Is the Insured/Participant also insured in other company or insurance firm? (Must be filled, if any) ☐ Yes ☐ No

The name of such other company/insurance firm:

Declaration and Authorization

I. I here by grant power and authority to PT AIA FINANCIAL to ask for and/or obtain any and all medical history, diseases, and treatments records or other information pertaining to the Insured/Participant ("Information") from Physicians/Paramedics/Administration Staff of Hospitals/Clinics/Public Health Center and/or Laboratories, insurance firms, reinsurance firms, bodies, institutes/agencies or other parties ("Information Providers") holding such Information for life insurance application, change of my policy in PT AIA FINANCIAL,claim processing, investigation, policy administration, data analysis and/or customer service provision("Purposes"). I/we grant power and authority to every Information Provider keeping Information to furnish such information to PT AIA FINANCIAL for Purposes. This power of attorney can't be revoked or annulled including for the grounds prescribed in Article 1813, Article 1814, and Article 1816 of Civil Code of Indonesia. Copy of this power of attorney shall have equal legal authority and binding effect to the original

II. I hereby authorize PT AIA FINANCIAL (including employees, Board of Directors, or other attorneys of PT AIA FINANCIAL) to conduct verification and checkings relating to my claim in PT AIA FINANCIAL to company, insurance company or other party whatsoever.

III. During the validity of Policy, I agree to furnish information of any kind relating to my policy in other company or insurance firm.

IV. This power of attorney can't be revoked or annuled and shall remain valid during my life and the reafter as of my demise. Copy of this power of attorney shall have equal legal authority and binding effect to the original.

V. I hereby release and hold harmless any relevant party from any and all claims, demands, complaints and other similar legal actions in civil or criminal case in relation to this authorization and/or its performance.

VI. I shall pay and/or reimburse any cost incurred from medical actions including any cost overrun and other exclusions not covered under the Policy.

VII. All information provided in this Claim Form is complete and consistent with the actual condition and no information or otherwise has been concealed or falsified.

VIII. For any blank or unfilled Claim Form despite my signing, I shall fully be held responsible for any legal consequence and/or damage that may arise therefrom.

IX. The option of proposing Inpatient Benefit and/or Outpatient Benefit in this Claim Form has been made at my sole decision without any duress and I have read and understand declaration in this Claim Form and sign it in responsible manner. For any untrue or falsified information in this Claim Form or in case of document manipulation or double claim to other company or firm or otherwise, which is in contradiction with the applicable laws, I shall be available to accept any consequence from PT AIA FINANCIAL including termination of my PT AIA FINANCIAL policy ("Policy"), to return any proceeds from claim payment paid by PT AIA FINANCIAL to me and/or to acknowledge full discretion of PT AIA FINANCIAL to bring this case to the competent authorities.

X. If Policy Holder prefers to claim Inpatient Benefit and/or Outpatient Benefit to other company or insurance firm, claim payment by PT AIA FINANCIAL shall not exceed total costs spent by Policy Holder to such claim.

XI. A claim can be filed by submitting documents in electronic way as determined by PT AIA FINANCIAL. I shall keep the originals of documents supporting the claim that have been sent electronically to PT AIA FINANCIA The documents of claim are at my possession and will be kept until the next 6 (six) months as of the date of my claim filing. If needed and requested by PT AIA FINANCIAL at any time, I will be available to furnish all originals of documents supporting the claim that have been submitted electronically to PT AIA FINANCIAL.

Date/Month/Year	The Insured/Participant's Signature

PART 2: FILLED BY THE ATTENDING PHYSICIAN

To the Attending Physician
To process claim of our customer, please kindly complete the sections below. Thank you.

1. Service Date from (dd/mm/yy) ☐☐ ☐☐ ☐☐☐☐ to (dd/mm/yy) ☐☐ ☐☐ ☐☐☐☐

2. Registration No. of Patient/Hospital: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

3. Name of Hospital/Clinic: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

4. Type of treatment (Choose 1): ☐ Outpatient ☐ Dental ☐ Optic

5. Anamnesis:

6. Is there any other disease/symptoms relating to his/her present conditions? If any, please specify and since when:

7. If inpatient treatment is necessary, what is the medical indication supporting such treatment?

8. From the collected information, did the patient suffer same conditions previously before the date of your treatment? If yes, pleas specify (dd/mm/yy)

9. Physical examination:

10. Supporting checkups :

11. For dental treatment, please specify the regio and number of teeth:

12. Diagnosis: ICD 10:

13. Other Diagnosis ICD 10:

14. Treatment/therapy:

15. Recommended treatment:

17. The disease has relation with: (Choose 1)

- ☐ Cosmetics
- ☐ Fertility
- ☐ Congenital
- ☐ Psychic/psychosomatic
- ☐ HIV/AIDS
- ☐ Drug/alcohol abuse
- ☐ Suicide attempt/self-inflicted
- ☐ Others, specify
- ☐ Sexually transmitted disease

MEDICAL HISTORY

	Date	Name of Disease	Name & Address of Attending Physician/Hospital/Clinic
a. b. c.			

I faithfully acknowledge that I have examined the Disease/Wound suffered by the patient below.
I certify that all information above is true to the best of my knowledge and belief.

Name of Physician:

Physician License (SIP):

Address and Phone No:

/ / Date Month Year	Signature & Seal of Physician/Seal of Hospital/Clinic