CLAIM FORM INPATIENT

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 signevd 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.

3. All claims must be submitted to PT AIA FINANCIAL no later than 30 (thirty) days after the treatment.

PART. 1 FILLED BY THE CLAIMANT

Policy No : Participant No : Gender ☐ Male ☐ Female

Name of the Insured : Date of Birth: (dd/mm/yy)

Name of Participant

ID Card/Passport/ Driv. License)

Correspondence Address RT/RW:

(Must be filled, if the given address is different from data in PT AIA FINANCIAL, PT AIA FINANCIAL will revise with the address appearing in this Claim Form).

Town/Village City/District

Home Phone Hand Phone

Office Phone Email

Product (Choose 1): ☐ HS ☐ HS Plus ☐ PHS ☐ PHS Plus ☐ HCP

Type of Claim (Choose 1): ☐ Inpatient ☐ Pre-Inpatient ☐ Post-Inpatient ☐ ODS/ODC

If the reason is accidentt, 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. 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.

II. 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.

III. 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 insurance firm or otherwise, which is incontradiction 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.

IV. 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

V. A claim can be filed by submitting documents in electronic way as determined by PT AIA FINANCIAL. I must keep the originals of supporting documents of claim electronically submitted to PT AIA FINANCIAL and shall send to PT AIA FINANCIAL no later than 3 (three months after my claim filing. For my failure to submit the originals of supporting documents of claim within 3 (three) months, I must return the proceeds of claim that have been paid and my Policy shall declare void. Policy termination shall follow provisions applicable for the Policy.

REQUEST FOR THE PAYMENT OF INSURANCE BENEFITS

If the claim is approved, the payment shall be transferred to:

Currency ☐ Rupiah ☐ USD

Name of Account Holder

Bank Name

Account Number

Purpose or reason (if the payment is not paid to the Insured/Participant/Policy Holder)

The relationship with the Insured/Participant/Policy Holder

* The payment must be made to the Designee/Attorney. Otherwise, the Designee/Attorney must affix his/her signature over stamp while specifying the purposes / reasons.
* The payment of Policy Benefits other than Death Benefit for CITIBANK customers, shall be transferred to the account appearing in Life Insurance Application Form/Account Debit Authorization (SPAJ/SKDR). 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 Centers and/or Laboratories, insurance firms, reinsurance firms, bodies, institutes/agencies or other parties ("Information Providers") holding such Information for life insurance application, policy change, 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. I/we hereby acknowledge that all documents used to fulfill requirements for the claim shall become vested in PT AIA FINANCIAL as of their submission to PT AIA FINANCIAL for this claim filing.

Date/Month/Year	The Insured/Participant's Signature	Policy Holder'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 (dd/mm/yy): ☐☐ ☐☐ ☐☐☐☐ to ☐☐ ☐☐ ☐☐☐☐
2. Registration No. of Patient/Hospital
3. Name of Hospital/Clinic
4. Anamnesis
5. When did the patient see you for first consultation of his/her health conditions?
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, please specify (dd/mm/yy)
9. Physical examination:
10. Supporting checkups
11. If the treatment is due to pregnancy,
    The age of pregnancy: Week:
12. Diagnosis: ICD 10:
13. Other Diagnosis ICD 10:
14. reatment/theraphy:
15. If case of Sectio Cesaria, what is medical indication supporting such action?
16. 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.			

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