Claim Form

IMPORTANT INSTRUCTIONS TO COMPLETE YOUR CLAIM:

(i) Sections A and B must be completed for all claims, with signed declaration in order for APRIL Hong Kong Limited ("the Company") to identify who is making the claim, otherwise the claim may not be processed.

(ii) Section C must be completed by your Attending Physician if this is the first time you are claiming for a major or chronic illness, or if the claims involve any of the following: an in-patient stay, surgery including outpatient surgery, emergency room services, advanced imaging such as MRI/CT/PET.

(iii) The Company reserves the right to ask for additional information in respect of any claim, including the completion of any section of this claim form, if appropriate. The Company may also obtain information about your medical health before making a decision about your claim.

SECTION A (To be completed by the member or parent if a minor)

A1. Policy/Member Information

Policyholder Name:	Patient Name:
Policy number:	Member Number:

A2. If necessary, how can the Company contact you about the current claim?

(Please contact our policy department at ops.indo@april.com if you want to update your policy's contact details.)

☐ Email *(recommended)*:	☐ Telephone (include country & area code):	☐ Through someone else (indicate relationship):

A3. Reimbursement Method

Bank account details (if different from policy)

Bank Name:	Bank Address:	
Account Name:		Account Number:
Sort Code:	IBAN Code:	BIC (Swift) Code:
Correspondent Bank Details (if applicable):		

SECTION B (To be completed by the member or parent if a minor)

B1. If this claim pertains to illness:	B2. If this claim pertains to an accident:
a. Briefly describe your symptoms, and when and how they first occurred. When did you first consult a doctor about this problem or these symptoms? (Use space below if necessary).	a. Briefly describe how this injury occurred (include date, time & exact place):
b. Have you ever had a similar illness or similar symptoms? ☐ Yes ☐ No	b. Did this accident involve another person or your employment? ☐ Yes ☐ No
c. Have you sought medical care for this illness or these symptoms before? ☐ Yes ☐ No	c. Do you have other insurance which may cover this condition/ treatment? ☐ Yes ☐ No
d. Is any part of this claim for checkup or vaccination? ☐ Yes ☐ No	
e. Do you have other insurance which may cover this condition / treatment? ☐ Yes ☐ No	d. Is there any other source of compensation which may cover this condition / treatment? ☐ Yes ☐ No
If yes to questions b, c, or d above please supply additional details below. (For questions B1(e) or B2, state whether compensation / coverage will be sought or given).	

Space for additional details:

Declaration

I hereby declare that all information provided on this form and the documents submitted herewith are 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.

Authorisation for Release of Information

I authorise any doctor, hospital, or other health provider or facility, insuring or reinsuring company, or employer to release to the Insurer any information or records they may have regarding my health, tests or treatments I have received, and benefits or compensation therefor. If this claim relates to an accident, past or present, I also authorise any governmental body, agency, or other person or organisation who may have records pertaining to such accident to release such records or information.

I understand that this information will be used by the Insurer to determine eligibility for benefits, and that any information obtained will not be released by the Insurer to any person except to reinsuring companies or other persons or organisation(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 (Parent if minor) _____ **Date** _____

For Office Use Only: Claim Sub Ref _____

Patient Name:	Policy / Member number:

SECTION C (To be answered by the attending physician at the claimant's expense)

Please "✓" check as appropriate

C1. ☐ Illness **C2. ☐ Accident / Injury**

a. When did the symptoms first appear and initial diagnosis	a. Describe briefly the mechanism of the accident / injury, and give the final/provisional diagnosis
b. Final diagnosis and when was it made	b. Date of accident or injury
c. Date the patient first consulted you about these symptoms / condition	
d. Is this the first time the patient has experienced these symptoms or similar condition? ❑ Yes ❑ No (please give details below)	
e. Are you the first medical practitioner the patient has seen about these symptoms or similar condition? ❑ Yes ❑ No (please give details below)	
f. Has any procedure, service, or test been recommended but not completed? ❑ Yes (please give details below) ❑ No	

C3. ☐ Surgery *(please provide operation notes & biopsy report(s), if any)* **C4. ☐ Pregnancy/fertility/sexual dysfunction**

Date(s) of surgical procedure performed	Do these services relate to pregnancy? ❑ Yes (please give details below incl. est. delivery date or LMP, and indicate if this pregnancy is the result of assisted conception or infertility treatment) ❑ No
Name(s) of surgical procedure performed	Is this claim related to infertility or sexual dysfunction (including services intended to increase chances of conception or carrying pregnancy to term)? ❑ Yes (please give details below) ❑ No

PLEASE PROVIDE ALL INVESTIGATION / LABORATORY / PATHOLOGY REPORT(S) AND DISCHARGE SUMMARY, IF ANY

Space for additional details:

Attending Physician's particulars

Name of Attending Physician:	Telephone:	Fax:
Address:	Email:	

Signature and official stamp of Attending Physician **Date**

Please send completed form to:

PT.Asuransi Artarindo
Gedung Hermina Tower Lt. 12,
Jl. HBR Motik Blok B-10 Kav. 4 Gunung Sahari
Selatan, Kemayoran, Jakarta Pusat 10610
Tel: (+62) 21 3971 1002 | Fax: (+62) 021 3971 1001
Or claims.indo@april.com

❑ Have you completed Section A & B?
❑ Have you signed the Declaration and Authorisation for Release of information?
❑ Have you enclosed the original bills and receipts showing what services were rendered and the charge for each?
❑ If required, has your physician completed and signed Section C, and attached any laboratory, scan, or other reports?
❑ If you have other insurance, a copy of the explanation of benefits from that claim?