Prior Agreement Authorisation Form – Hospitalisation

IMPORTANT NOTES

Hospitalisation expenses will only be reimbursed by Henner-GMC, on behalf of AIG, if AIG has granted prior agreement to such hospitalisation based on the information in this document, which must be completed by the attending Physician and sent by fax or email to:

AIG Asia Pacific Insurance Pte. Ltd. (c/o Henner-GMC)
Fax: +65 6751 5047
Email: aig.apac@henner.com

This form must be submitted no later than 10 days prior to the date of hospitalisation. In the event of a medically justified emergency, this form must be submitted within 3 days following admission. If Henner-GMC approves the hospitalisation, it will issue a guarantee of payment, on behalf of AIG, which will be sent directly to the designated hospital. Henner-GMC will notify the insured person in the event of a refusal.

Name of Patient	**Date of Birth**

SECTION A - DETAILS OF HOSPITALISATION

Name of Principal Doctor and Clinic

Name of Hospital/Surgery Centre

Ward Type

Private

- ☐ Day Surgery
- ☐ Standard Single Bed
- ☐ Others: _____
- ☐ 2 Bed
- ☐ 4 Bed

Public/Restructured

- ☐ Day Surgery (subsidised)
- ☐ Day Surgery (non-subsidised)
- ☐ Class A
- ☐ Class B1/B1+
- ☐ Class B2/B2+
- ☐ Class C

Date of Admission

Est. Length of Stay (No. of days)

Is the condition typically managed on an outpatient basis? If Yes, please provide reason for this hospitalisation.

☐ No ☐ Yes, reasons are:

Date of first consultation of symptoms

Date of first diagnosis

Precise medical diagnosis (please include ICD code)

Date of onset of symptoms/Duration of symptoms & Description of symptoms

Nature of the proposed operation and treatment program

Is the treatment due to/related to/as a result of any of the following condition(s)?

- ☐ Clinical trial/study/experimental
- ☐ Routine check-up/screening
- ☐ Self-inflicted injuries/attempted suicide
- ☐ Alcohol/drug abuse
- ☐ Correction for refractive errors of eye
- ☐ Congenital anomaly/genetic disorder/ physical defects from childbirth
- ☐ Obesity/weight reduction
- ☐ Mental/psychiatric disorder
- ☐ Elective cosmetic/plastic surgery/dental
- ☐ STD/HIV/AIDS related

Does the patient have any of the following major comorbidities?

Comorbidities	**Date of diagnosis**
☐ Cancer	
☐ Stroke, Heart Failure, Cardiovascular Disease	
☐ Diabetes	
☐ High Cholesterol	
☐ Hypertension	
☐ Kidney Failure	
☐ Others: Please state	
☐ Previously suffered the same or related diagnosis/illness/symptoms	

Name of Clinic and Doctor who had treated the patient for the above comorbidity, if available

SECTION B - ESTIMATED COSTS

Estimated cost of the hospitalisation:

Hospital charges -

Other expenses (medicines, medical supplies, tests, scans, etc) -

Physician's fees -

SECTION C - PRINCIPAL DOCTOR'S DECLARATION & SIGNATURE

1. I represent and warrant that:
   (a) I have personally examined and treated the Insured (i.e. patient) in respect of the medical condition described above and that the information stated above represent my genuine and honest opinion of his/her condition and my recommended treatment; and
   (b) the answers given above are true, accurate and complete to the best of my knowledge and belief and that no information has been withheld.

2. I agree and authorise AIG Asia Pacific Insurance Pte. Ltd. to release all information contained in this form (including medical information), with the patient's consent if such disclosure is required by the Financial Industry Disputes Resolution Centre Ltd (FIDReC) of Singapore or any claim dispute resolution organisation.

Physician's signature and hospital/clinic stamp:

Date

For queries, please call Henner-GMC at +65 6751 5271

Patient's signature:

I hereby authorise my Physician to send to Henner-GMC and AIG and all of their authorised agents, employees, consultants and service providers all information contained in this form (including medical information) required by AIG for making a decision on my claim.