Authorised claim administration representative of AIA
AIA refers to subsidiaries and affiliates of AIA Group Ltd

AIA Shared Services Sdn. Bhd.
Wisma Mustapha Kamal, Menara 2,
02-06-01, NeoCyber Lingkaran Cyber Point Barat, Cyber 12
63000 Cyberjaya, Selangor Darul Ehsan, Malaysia

Regional Passport Hotline
Hong Kong: 852 2100-1214
Malaysia: 1-800-81-8826
Singapore: 800-852- 6788
Thailand: 001800-852-3898

AIA REGIONAL PASSPORT PRE-AUTHORISATION FORM

Important Notes:

a) For admission, please complete this request form in order to enjoy cashless service.
b) Please read the consent section and sign to indicate your understanding of your obligations and ensure that you have signed the "Authorisation and Declaration".
c) Please complete the form as soon as treatment is recommended. You will be informed to obtain the attending doctor statement on Part II to providedetails of the medical history and proposed treatment. Please initiate the request at least 7 days before the date of planned treatment so that we havesufficient time to obtain medical & treatment details from attending doctor.

PART I (To be completed by Insured or Policy Owner and/or Insured Member)

A) Particulars of Insured (Patient)

Name of Insured (Patient):	NRIC / Passport No. / FIN No. / ID Card No.:	Citizenship:	
Policy No.:	Certificate No. (CS only):	Date of Birth: DD/MM/YYYY	Gender: M / F
Contact No.:		Email Address:	

☐ Please tick the box if you do not want AIA to inform your agent about this hospitalisation Letter of Guarantee application.

B) Particulars of Policy Owner (If not the Patient)

Name of Policy Owner:	Relationship to Insured (Patient):
NRIC / Passport No. /FIN No. / ID Card No.:	Contact No.:

C) Details of Insured's Regular Doctor(s)

Name of Doctor	Name & Address of Clinic	Date of Consultation	Reason for Consultation / Treatment	Diagnosis
		DD/MM/YYYY		

D) Details of Other Medical Insurance

If you are entitled to reimbursement from any parties under an obligation (whether contractual or otherwise) to pay you the expenses incurred in your medical treatment or healthcare services under your claim, such as an insurer, government, your employer or any other person, we shall be the last person reimbursing you for your expenses. For every claim, the total reimbursement from such persons must not exceed the expenses actually incurred.

The Insured is required to give the details of his/her other insurance plans, government agency, employer or other person making the reimbursement of expenses below:

Name of Employer	Group Insurance Policy Number	Type of Plan
Name of Insurance	**Company Individual Insurance Policy Number**	**Type of Plan**

E) Declaration and Authorisation

1. I / We:
   (a) accept that the furnishing, acceptance of this form or of any forms supplemental thereto and / or any payments, under or in connection such forms or the letter(s) of guarantee subsequently issued ("LOG"), does not constitute and shall not be construed as admission of liability or that there was any insurance in force, by AIA Shared Services Sdn. Bhd. ("**AIA Shared Service**s") and / or its agents or representatives whether in respect of such forms, under the relevant insurance policy, LOG, or otherwise nor a waiver of any of its rights or defenses;
   (b) accept that the issuance of the LOG and any payments thereunder shall be at the sole and absolute discretion of AIA Shared Services;
   (c) hereby jointly and severally liable for any sums paid or payable to or by AIA Shared Services, the medical institutions and professionals, its and their representatives, each of which reserves its respective rights to recover such sums that may be attributed or attributable to the treatment or other services provided to the Insured which are inadmissible under, excluded by, or which exceed, the coverage of the relevant insurance policy (whether wholly or partially) and I / we hereby indemnify eachsuch party in respect of all such sums;
   (d) hereby declare that I / we are duly authorized to make this application and all statements and responses whether on this form or otherwise together with any requiredquestionnaire, amendments, materials and supporting documents submitted in connection herewith and the Policy ("Information");
   (e) declare that all information declared to AIA for the purpose of the Policy and its coverage, including current application is complete, true and correct and that noinformation or materials have been withheld and that AIA Shared Services will rely and act on the Information accordingly and accept that AIA Shared Services shallbe at liberty to deny liability and / or recover any sums paid, whether wholly or partially, if any of the Information is incomplete, untrue or incorrect in any respect or if the relevant insurance policy does not provide cover; and
   (f) accept that AIA Shared Services expressly reserves its rights to require or obtain further information as it deems necessary.
2. I / We hereby authorize, agree and consent to:
   (a) persons and organizations, whether within or outside AIA Shared Services, including but not limited to medical sources, hospitals, doctors, other healthcare professionals, laboratories, regulators, dispute resolution centres and insurers, their associated persons/organizations, my/our or the insured person's employers or finance service providers, or their third party service providers or representatives (collectively "**Third Parties**") disclosing and releasing to AIA Shared Services, its associated persons/organizations, its and their third party service providers and its and their representatives (collectively "**AIA Persons**"), any information concerning the policy owner and the insured person(s) at any time, including all personal data and information, medical information, medical history, consultation history and notes,prescription, treatments, descriptions ormedical services rendered, and any employment and financial information, including the taking of copies of such records (collectively "Personal Data"), relevant for the Purpose (defined below);
   (b) the AIA Persons sharing the scope of the sub-clause (a) above, along with any of the Personal Data, with any relevant Third Parties to procure their disclosure andrelease of additional relevant Personal Data for the Purpose;
   (c) the AIA Persons, including their approved medical examiners or laboratories, performing any necessary medical assessments and examinations and tests todetermine, assess and evaluate the health of the insured person(s);
   (d) the AIA Persons collecting, using, disclosing, storing, retaining and / or processing (collectively, "Using" / "Use") the Personal Data for the Purpose; and
   (e) waive any right (on my own behalf and on behalf of the insured person(s) where applicable, in respect of which I / we represent and warrant that the insured person(s) have granted me / us authority to so waive) to bring a claim of any nature against any of the AIA Persons in respect of any above-mentioned Use and/or any Use of any Personal Data for the Purpose.

Where I / we are not the insured person, I / we represent and warrant that I/we have obtained the consent of the insured person(s), except to the extent such consent is not required under relevant laws: (i) to collect their Personal Data; (ii) to disclose their Personal Data to the AIA Persons; and (iii) for the AIA Persons and Third Parties to Use any of their Personal Data in the manner and for the purposes described in this Clause. I / We hereby agree to indemnify AIA Persons for all losses and damages that AIA Persons may suffer in the event that I / we are in breach of any representation and warranty provided by me / us herein. In this Clause, "**Purpose**" means any of the purposes described in the AIA Personal Data Policy, including but not limited to processing of this form, to provide subsequent advice or services to me/us or the insured person in relation to any existing or future policy/policies/ programmes that I/we may hold / participate with AIA Shared Services.

3. I / We agree that the personal contact details provided can be used for communication onmatters relating to this application and subsequent claims
4. This authorisation and declaration shall bindmy / our successors and assignees, and remain valid, notwithstanding death or incapacity. I / We agree that a photocopy of thisauthorisation shall be effective and valid as the original.

F) Personal Data Collection and Use

I hereby:

1. Confirm that I have read and understood the PRIVACY STATEMENT which is available on AIA website: https://www.aia.com.hk/en/privacy-statement-main.
2. Declare and agree that any personal data and other information relating to me or my Policy contained in this application or collected, obtained, compiled or held by AIA Shared Services Sdn. Bhd. ("**AIA Shared Services**") by any means from time to time may be collected and utilised in accordance with the **PRIVACY STATEMENT**.
3. Authorize AIA Shared Services, its associated persons / organisations, its and their third party service providers and its and their representatives, (collectively "AIA Persons") to collect, use, disclose, store, retain and/or process all personal data and information that had / has been provided to AIA Persons and / or that AIA Persons possess about me (whether from me or a third party), in the manner and for the purposes described in the PRIVACY STATEMENT, including but not limited to, processing of this Regional Passport Service request and / or to provide subsequent advice or services to me in relation to this request, my Policy and / or any other existing or future policy/policies/programmes that I may hold / participate with AIA Persons.
4. Understand that the medical services provided by the medical service provider I select in any applicable location is an agreement between myself and such medical service provider. I acknowledge that I do not have any recourse against AIA Persons for the services provided by the medical service provider I select.
5. Hereby authorise, agree and consent to the relevant medical service provider disclosing, transferring and sharing my personal and medical information, including but not limited to my medical history, consultations, treatment, prescriptions, diagnoses and other relevant information including hospital and medical data, records and reports to enable AIA Persons to carry out its services under this Regional Passport programme. I understand and acknowledge that without such consent(s), or upon the withdrawal of any such consent(s), AIA Persons may not receive the required information or data, and therefore may not be able to provide the required services and in such circumstances, I will not hold AIA Persons liable or responsible for its failure to do so.
6. Acknowledge that any travel expenses incurred by me for the medical treatment are my responsibility. Such costs are not covered by my Policy and will not reimbursable.
7. Understand that this authorisation request or approval does not guarantee that total charges by the medical service provider are totally covered by my Policy. I hereby undertake the responsibility to settle any amounts in excess of the coverage, or services that are not covered by my Policy upon receiving notification from AIA Shared Services.

Signature of Policy Owner: *(to leave blank if it is a Corporate Solutions policy)*	**Signature of Insured / Member:**	**Signature of Witness:** *(to leave blank if it is a Corporate Solutions policy)*
Name of Policy Owner: *(to leave blank if it is a Corporate Solutions policy)*	**Name of Insured/Member:** *(Parent/Guardian if Insured is below 18 years old)*	**Name of Witness:** *(to leave blank if it is a Corporate Solutions policy)*
ID No of Policy Owner: *(to leave blank if it is a Corporate Solutions policy)*	**ID No. of Insured:** *(to leave blank if it is a Corporate Solutions policy)*	**ID No. of Witness:** *(to leave blank if it is a Corporate Solutions policy)*
Date: DD/MM/YYYY	**Date:** DD/MM/YYYY	**Date:** DD/MM/YYYY

PART II CERTIFICATE OF MEDICAL ATTENDANTA

A) Particulars of Insured (Patient)

Name of Insured (Patient):		NRIC / Passport No. / FIN No. / ID Card No.:	
Citizenship:		Date of Birth: DD/MM/YYYY	Gender: M / F
Policy No.:	Certificate No. (CS only):	Contact No.:	

B) Particulars of Principal Doctor

Name:	Specialty:

C) Detail of Patient's Current Admission

Hospital / Clinic:	Nature of Treatment *(Please tick accordingly)*: ☐ Day Care ☐ Hospitalisation
Planed Treatment Date: DD/MM/YYYY	Estimated length of stay (days):
Planned Admission Date: DD/MM/YYYY	Planned Discharge Date: DD/MM/YYYY

Reason for admission:

Diagnosis Code (e.g. ICD-10AM)	Diagnosis Description	Principal Diagnosis	Symptoms presented	1st consult date	1st diagnosis date	1st onset date of symptom(s)
		☐		DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
		☐				
		☐				

Is the principal diagnosis a result of any underlying medical condition? ☐ Yes ☐ No
If "Yes", please provide details.

Did the patient ever consult any other doctor(s) previously for theabove condition? ☐ Yes ☐ No
If "Yes", please provide name and contact details of the doctor.

Is the patient's diagnosis / injury: ☐ due to accident ☐ an acute condition ☐ None of the two?

If it is due to 'accident', please provide details of the accident, including cause of the injury and anatomical site involved.

Is the treatment or condition due to / related to / as a result of any of the conditions listed below? If "Yes", please tick the relevant box(es).

- ☐ Pregnancy / childbirth / infertility / Caesarean section / miscarriage / abortion Or any complications arising therefrom
- ☐ Congenital anomaly / hereditary diseases / genetic disorder / physical defects from childbirth
- ☐ Influence of drugs / alcohol / intoxicant
- ☐ Mental / emotional / psychiatric disorder
- ☐ Elective cosmetic / Plastic surgery / Dental care / Refractive errors of eye correction
- ☐ STD / VD / HIV / AIDS related
- ☐ Self-inflicted injuries / attempted suicide / violation of laws / strike / riots
- ☐ Obesity / weight control
- ☐ Routine check-up / screening
- ☐ Birth control / Sterilisation
- ☐ Impotence test / treatment
- ☐ Clinical trial / study / experimental

D) Treatment details

a. Please advise treatment plan including tests and investigations for this patient:

b. If there is surgery, please complete section below.

Date of Operation	Diagnosis for which procedure will be performed	Procedure Code (e.g. ICD9 Code, TOSP)	Procedure Description	Remark
DD/MM/YYYY				
DD/MM/YYYY				

Does the patient have any of the following condition(s):

- Hypertension (High Blood Pressure)? ☐ No ☐ Yes
- Diabetes? ☐ No ☐ Yes
- High Cholesterol? ☐ No ☐ Yes
- Back Pain? ☐ No ☐ Yes
- Neck Pain? ☐ No ☐ Yes
- CVA, Cardiovascular disease, Heart failure? ☐ No ☐ Yes
- Cancer? ☐ No ☐ Yes
- Kidney failure? ☐ No ☐ Yes
- Others underlying disease? ☐ No ☐ Yes

If "Yes" for any of the above, please indicate diagnosis date and details of treating doctor of the condition.

E) Cost Estimation

E) Cost Estimation	Remarks
(1) Total Professio Fees Breakdown as:	
(2) Total Attendance Fees	
(3) Total Other Fees (e.g. Secondary treating doctors' fees, surgical implant, medical consumables, and other charges) Breakdown as:	
(4) Total Room & Board Fees (Please indicate number of days of stay, ward type and charges)	
(5) Total Estimated Hospital Charges	
(6) Total Estimated Bill Size = 1+2+3+4+5F	

Procedure Code and Description:	
Surgeon fees	
Anaesthetist fees	

Procedure Code and Description:	
Surgeon fees	
Anaesthetist fees	

Procedure Code and Description:	
Surgeon fees	
Anaesthetist fees	

a.		
b.		
c.		
d.		

F) 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 theinformation 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 authorize AIA Shared Services Sdn. Bhd. to release this medical information if such disclosure is required by law or by any Government authority.

Name of Doctor: _____

_____ **Doctor's Signature / Date** (DD/MM/YYYY)

_____ **Official Stamp of Hospital / Clinic**

G) Discharge Section (To Be Completed Upon Discharge by Doctor)

Letter of Guarantee / Top Up Letter of Guarantee Reference No.:	Date of Discharge: DD/MM/YYYY

Final Diagnosis and diagnosis code:

Treatment given / Investigation done (Please supply copy of all investigation results):

Surgical procedures performed (if any):

Date of Operation	Diagnosis for procedure performed	Procedure Code	Procedure Description	Remarks
DD/MM/YYYY				
DD/MM/YYYY				

Recovery complication that arose (if any):	In the case of DEATH, please advise Date/ Time and Cause of death:

I hereby certify that I have personally examined and treated the Patient for his/her injuries/illness described above and that the facts as stated above represent my medical opinion of his/her condition.

Date: (DD/MM/YYYY) _____ Name & Signature of Attending Doctor _____ Official Stamp of Hospital / Clinic

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AIA REGIONAL PASSPORT
PRE-AUTHORISATION FORM (DISCHARGE SECTION)

PART 2 CERTIFICATE OF MEDICAL ATTENDANT (to be completed upon DISCHARGE)

Particulars of Insured (Patient)			
Name of Insured (Patient):		NRIC / Passport No. / FIN No. / ID Card No.:	
Citizenship:		Date of Birth: DD/MM/YYYY	Gender: M / F
Policy No.:	Certificate No. (CS only):	Contact No.:	

Particulars of Principal Doctor	
Name:	Specialty:
Hospital:	

G) Discharge Section	
Letter of Guarantee / Top Up Letter of Guarantee Reference No.:	Date of Discharge: DD/MM/YYYY
Final Diagnosis and diagnosis code:	
Treatment given / Investigation done (Please supply copy of all investigation result**s):**	
Surgical procedures performed (if any):	

Date of Operation	Diagnosis for procedure performed	Procedure Code	Procedure Description	Remarks
DD/MM/YYYY				
DD/MM/YYYY				

Recovery complication that arose (if any):	In the case of DEATH, please advise Date/ Time and Cause of death:

I hereby certify that I have personally examined and treated the Patient for his/her injuries / illness described above and that the facts as stated above represent my medical opinion of his/her condition.

Date (DD/MM/YYYY) _____ Name & Signature of Attending Doctor _____ Official Stamp of Hospital / Clinic _____