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, Day Surgery, please complete this request form in order to enjoy cashless service
b) Please read the consent section and sign to indicate your understanding your obligations.
c) Please complete the form as soon as treatment is recommended. Upon receipt of the Request Form, you will be informed to obtain the attending doctor statement on Part II to provide details of the medical history and proposed treatment. Please initiate the request at least 7 days before the date of planned treatment so that we have sufficient time to get medical & treatment details from attending doctor.
d) Please ensure that you have signed the "Authorization and Declaration" selection using the same signature as in AIA Thailand's records.
e) Please submit completed PAF part I and part II form via email to Th.Regionalpassport@aia.com

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: ***(For foreigners, please submit a copy of your valid pass)***	Date of Birth: DD/MM/YYYY	Gender: M/F
Policy No./ Certificate No.:	Contact No.:	
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

LAST PAYER STATUS

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 other insurance plans, government agency, employer or other person making the reimbursement of expenses in the space appearing below:

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

Name(s) of any other person obliged to pay for the expenses incurred in medical treatment or healthcare services of Insured (e.g. employer, government agency, or organisation):

Name	Address	Contact Number of Person in charge

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 Company Limited. ("**AIA Thailand**") 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 Thailand;
   (c) hereby jointly and severally liable for any sums paid or payable to or by AIA Thailand, 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 each such 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 required questionnaire, 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 no information or materials have been withheld and that AIA Thailand will rely and act on the Information accordingly and accept that AIA Thailand shall be 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 Thailand 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 Thailand, 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 Thailand, its associated persons/organizations, its and their third party service providers and its and their representatives, whether within or outside Thailand (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 or medical 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 and release 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 to determine, 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 Thailand.

3. I/We agree that the personal contact details provided can be used for communication on matters relating to this application and subsequent claims

4. This authorization and declaration shall bind my/our successors and assignees, and remain valid, notwithstanding death or incapacity. I/We agree that a photocopy of this authorization shall be effective and valid as the original.

F) Personal Data Collection and Use

I/We confirm that I/we have read and understood the AIA Personal Information Collection Statement ("AIA PIC"). I/We declare and agree that any personal data and other information relating to me/us or my/our policy(ies) contained in this application or collected, obtained, compiled or held by the Company by any means from time to time may be collected and utilised in accordance with the AIA PIC. Unless otherwise provided by the regulation, such personal data will be retained for another eleven years from the contract end date, contract cancellation date or contract terminated date, I/We acknowledge and consent to the transfer of my/our personal data outside of Thailand (for policies is sued in Thailand), as the case may be, for the purposes and to the types of transferee as set out in the AIA PIC. I/We understood that such the consent can be withdrawn at any time and I/we shall be entitled to request for access, copy, transfer, correct, erase, destroy, oppose or suspend the usage of the personal data under the regulation. In addition, I/we have right to complaint to the Expertized Committee according to the Data Protection Act of Thailand if such request has not been served in that regard pursuant to the regulation. The updated version of AIA PIC is available for download from its website: www.aia.co.th, and is made available upon request."

Signature of Policy Owner:	**Signature of Insured/Member:**	**Signature of Witness:**
Name of Policy Owner:	**Name of Insured/Member:** *(Parent/Guardian if Insured is below 20 years old)*	**Name of Witness:**
NRIC/Passport No. of Policy Owner:	**NRIC/Passport No. of Insured:**	**NRIC/Passport No. of Witness:**
Date: DD/MM/YYYY	**Date:** DD/MM/YYYY	**Date:** DD/MM/YYYY

PART II CERTIFICATE OF MEDICAL ATTENDANT

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 the above 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

Remarks

(1) Total Professional Fees

Breakdown as:

Procedure Code and Description:	
Surgeon fees	
Anaesthetist fees	

Procedure Code and Description:	
Surgeon fees	
Anaesthetist fees	

Procedure Code and Description:	
Surgeon fees	
Anaesthetist fees	

(2) Total Attendance Fees

(3) Total Other Fees (e.g. Secondary treating doctors' fees, surgical implant, medical consumables, and other charges)

Breakdown as:

a.		
b.		
c.		
d.		

(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+5

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 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 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