Customer Care Centre
AXA Tower lt. GF
Jl. Prof. Dr. Satrio Kav.18, Kuningan City
Jakarta 12940, Indonesia
Tel : 1500 733
Fax : +62 21 3005 9008
Email : customer@axa-insurance.co.id

Claim Form SmartCare Executive

Fullerton Health Indonesia

Important

1. Please complete this claim form and attached all related claim document refer to Claims Document Requirement on page 2.
2. Submit to the SmartCare Executive program administrator within 30 days after discharged from hospital or medical treatment.
   PT Fullerton Health Indonesia Group CIBIS Nine (CIBIS Business Park) Building 5th Floor
   Jl. TB Simatupang No. 2 Rt.001 Rw. 05 Kelurahan Cilandak Timur Kecamatan Pasar Minggu Jakarta Selatan 12560
   UP. CLAIM DEPT. Tel (+62 21) 2997 8997 Fax (+62 21) 2997 8955

Personal Data

Insured's Name : ……. Card member no : ……
Date of Birth : ……. Plan : ……
Gender : ☐ Male ☐ Female Job title : ……
Address : ……. Telephone : ……
……

Company Name : ……
Address : ……. Telephone : ……
……

For claim payment purposes, please complete the data below
Bank Name : ……. In the name of :……
Branch : ……. A/C No. :……
Total paid : ……

Authorisation to Release Information

I hereby authorise PT Asuransi AXA Indonesia and any other third party appointed by the Insurer without any time limit to obtain any information/medical records from hospital/clinic or other party acquired in the course of my examination or treatment or my family's medical history for the purpose of the settlement of my health insurance claims.according to the applicable law and regulation.. Copy of this statement and letter of authority has the same validity with the original Letter of Authority which is irrevocable during the enforcement of this SmartCare Executive Programe. I declare that to the best of my knowledge and belief, all information under this is true and correct.

Name & Signature

Place & Date (D/M/Y)

MEDICAL RESUME (must be completed by Physician)

1. Date of treatment : ……/……/…… to ……/……/…… (dd/mm/yy)
2. Registration No. : ……..
3. Name of hospital/clinic : ……..
4. Is the hospital/clinic listed as our provider ? ☐ Yes ☐ No
5. Type of treatment : ☐ Inpatient ☐ Dental Consultation
   ☐ Outpatient General Consultation ☐ Maternity
   ☐ Outpatient Specialist Consultation ☐ Optical (For optical benefit, please ignore item no. 4 till 9
6. Anamnesis :……
7. Physical Check Up : ……..
8. Support Check Up : ……..
9. Diagnosis : ……..
10. Therapy : ……..
11. Medical Advice : ……..

Physician's name, signature, and hospital/clinic stamp

Place

Date/Month/Year

Claims Document Requirement

No	Document Requirement	Type of Claim					
		In patient	Out patient	Accident	Hospital Cash	Death	Coordination Benefit
1	Original completed claim form *(filled by client)*	☐	☐	☐	☐	☐	☐
2	Completed medical resume *(filled by treating doctor, signed & stamped by Hospital)*	☐	☐	☐	☐	☐	☐
3	Copy of laboratory examination result & radiology/ other diagnostic examination	☐	☐	☐	☐	☐	–
4	Original receipt with details of medication fee, treatment fee & copy of prescriptions *(for the claim amount 1mio and above must be stamp IDR 6000)*	☐	☐	☐	–	–	–
5	Photocopy of Passport (*if treatment/dies at overseas*)	☐	☐	☐	–	☐	–
6	Copy of Insured / Participant ID Card (*for Group)*	☐	☐	☐	☐	☐	☐
7	Power of Attorney to request medical data	☐	–	–	☐	–	–
8	Photocopy of driver license & investigation report from the Local Police (*if an accident)*	☐	☐	☐	–	☐	–
9	Original receipt with details of medication fee, treatment fee, copy of prescriptions & copy of examination diagnostic result *(only if there is a coordination of benefit & hospital cash plan)*	–	–	–	☐	–	☐
10	Copy of insurable Interest between Insured and Beneficiary(s)	–	–	–	☐	☐	–
11	Copy Beneficiary(s) ID *(only for death claim allowance)*	–	–	–	–	☐	–
12	Power of Attorney from Beneficiaries if Beneficiaries more than one person / Certificate of heirs	–	–	–	–	☐	–
13	Legalized of Death Certificate from authorized institution	–	–	–	–	☐	–
14	Legalized of Death Certificate from General Consul of RI *(if dies at overseas)*	–	–	–	–	☐	–
15	Death of Chronology *(if dies at home or when go to Hospital)*	–	–	–	–	☐	–
16	Bank account Power of Attorney *(if the account owner is not the Benefit Receiver)*	–	–	–	–	☐	–
17	Insured Death of Certificate which has been authorized by legal Institution, States the Insured has been died, if the Insured was miss in accident	–	–	–	–	☐	–
18	Result Visum Repertum and investigation report fromLocal Police *(if dies due to accident)*	–	–	–	–	☐	–
19	Original receipt of the excess of the treatment *(only if there is a coordination of benefit and for claim amount 1mio and above must be stamp IDR 6000)*	–	–	–	–	–	☐
20	Statement letter with detail of claim payment from another Insurer/BPJSK *(only for coordination of benefit)*	–	–	–	–	–	☐

Note: ☐ Required
– Not Required

For claim amount up to Rp. 1 million can be submitted through WA at 0815 8670 7637 or MyAXA Health application.
For further information, please contact our Customer Care.