



# Claim Form SmartCare

Please use a separate claim form for each separate admission.

All claim submission documents must be in Indonesian or English. If it is necessary to translate into Indonesian or English, the translation must be carried out by a sworn translator at the expense of the Policy Holder/Insured.

Send this claim form together with all supporting documents **Health Claims Team, AXA Tower Lt. 12, Jl. Prof. Dr. Satrio Kav.18, Kuningan City, Jakarta 12940, Indonesia.**

The list of supporting documents can be accessed here: <https://myinsurance.axa.co.id/en/tata-cara-klaim-kesehatan>

## Personal Data

Insured's Name : ..... Member's Card No : .....

Date of Birth : ..... Gender :  Male  Female

Company Name : ..... \*\* Telephone No : .....

Has a claim been submitted with other medical insurance companies?  Yes  No **Note: \*\* Not Mandatory**

By signing this form, I declare that I have read, understood, and agreed to the following:

- Reimbursement Claim Payment Terms:** For reimbursement claim submission, claims payment will be transferred to the bank account that has been registered at the time of policy issuance. If there is a change in bank account data, the change can be submitted by filling out the Endorsement Form.
- Statement of Authorization from the Patient:** I hereby authorize the Administrator Program without any time limit to release any information/medical records from hospital/clinic providers or other party acquired during my examination or treatment or my family's medical history according to the applicable law and regulation. I agree to provide my medical records to **SmartCare** Program Administrator for medical and administration purposes. Copy of this statement and letter of authority has the same validity with its original which is irrevocable during the enforcement of this **SmartCare** Program. I declare that the best of my knowledge and belief, all information under this true and correct.
- Consent to the Processing of Personal Data:** I/ We hereby agree that the personal data and information that I/We provide to AXA Insurance whether directly and/or through third parties related to the claim, can be collected, processed, stored, and sent by AXA Insurance to other parties who cooperate with and/or are appointed by AXA Insurance, regulators, and authorized parties and/or Associations for purpose including but not limited to the purposes of my Insurance coverage reinsurance and claim process and other AXA Insurance operational activities in accordance with the applicable laws. Please access AXA Insurance Indonesia's Privacy Policy here: <https://www.axa.co.id/kebijakan-privasi>

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Name & Signature Place & Date (DD/MM/YY)

## Medical Resume (must be completed by Physician)

Please fill in this section with relevant, objective, and verified information which relevant with insured's claim.

1. Date of Treatment : ...../...../..... To ...../...../..... (dd/mm/yy)

2. Registration No. : .....

3. Name of Hospital / Clinic : .....

4. Type of Treatment :  Inpatient  
 Outpatient General Consultation  
 Outpatient Specialist Consultation  
 Dental Consultation  
 Maternity  
 Optical (For optical benefit, please ignore item no. 4 till 9)

5. Symptoms : .....

6. Physical Check Up : .....

7. Diagnostic Examination : .....

8. Diagnosis : .....

9. Therapy : .....

10. Medical Advice : .....

Physician's name, signature, Hospital/Clinic stamp, and SIP

Place & Date (DD/MM/YY)