



Claim Form SmartCare

FULLERTON HEALTH INDONESIA

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 to Fullerton Health Indonesia-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. 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:
1. 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.
2. 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.
3. 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>

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 :