Zoii Asia Pte Ltd
60 Paya Lebar Road #07-54 Paya Lebar Square Singapore 409051
Tel: +6588535076
www.zoii.asia

Claim Activation Form

To be completed by Insured. Please ensure that all medical documents/reports are submitted together with this form.

Home Country	Insurance Company	Insured ID
First Name	Middle Name	Last Name
Preferred Mode of Contact ☐ WhatsApp ☐ VIBER ☐ LINE ☐ Signal ☐ Telegram ☐ WeChat ☐ Others		
Mobile Number	Home Number	Office Number
Email Address		
National Identity Card Number	Passport Number	Nationality
Date of Birth (dd/mm/yyyy)	Gender Select Gender	For Admin Purpose Only (Language) ☐ English
Home Address (Country of Domicile)	Residential Address	
Person Submitting the Claims on behalf of the Insured Select Insured Relationship		
Policy Date (dd/mm/yyyy)	Policy Number	Policy Type
Full Name of Policy Holder (if Different from Insured)		Identification Number
Is this Insured's First Claim?	Start Date (dd/mm/yyyy) End Date	Previous CAF Number

Current Medical Specialist

Please provide all information accurately.

Specialist First Name	Specialist Middle Name	Specialist Last Name
Area of Specialty Select Area of Specialty	Medical Facility	
Recommended Treatment from Medical Specialist		
Have You Started on the Recommended Treatment? Select Yes or No		Start Date (dd/mm/yyyy) End Date
Are You Undergoing Any Other Medical Treatment? Select Yes or No		Start Date (dd/mm/yyyy) End Date
Other Medical Treatment Results		
How long has the insured been seeing the Medical Specialist?	Has insured consult any other physicians for other medical conditions Select Yes or No	
Next Step		
Has Insured undergone any surgeries for any of the above conditions? Select Yes or No	Does Insured have any allergy to any medications? Select Yes or No	
If YES, please provide more details below	If YES, please provide more details below	
Does Insured have a family history of medical conditions for this or any other diseases? Select Yes or No	If YES, please provide more details below	
Does Insured have any allergy to any medications?		
Insured Full Name	Date Submitted (dd/mm/yyyy)	

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Claims Form - Medical

If there is any personal data relating not to myself but to other individuals that I have furnished in the past, present & in the future, I warrant that I have obtained prior consent from these data subjects (or if they are lacking in legal capacity, from their legal representatives, guardians or parents as the case may be) for 60 Paya Lebar Road #06-33 Paya Lebar Square Singapore 409051 and its Appointees to collect, use and disclose their personal data for the above mentioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform Zoii Asia of any changes to the personal data to my knowledge as soon as practicable.

DECLARATION

1) I declare that I have complied with the conditions and warranties (if any) of the Policy and in no manner deliberately caused the said loss or damage or exaggerated the claim or sought unjustly to benefit by any fraud or willful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Zoii Asia reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.

   I authorise the release of any medical information necessary to process this claim.

_____ _____

Date (dd/mm/yyyy) Signature of Insured

_____ _____

Date (dd/mm/yyyy) Signature of Policyholder & Company Stamp

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