AUTHORIZATION OF BENEFIT (AOB)

PATIENT DETAILS

Name	Patient ID/Passport No	MRN/Admission Number
Mobile Phone – Available for Whatsapp	Principal's Name and ID	Admission Date & Time
Date of Birth/Age	Insurance	Policy Number
Room Charge Rp.	Standard Single Room Charge (1 room, 1 bed with bathroom inside) Rp.	Standard Single Room Charge (1 room, 1 bed without bathroom) Rp.

Reason for accupying current room (Mandatory to be filled in): (please tick one of the reason below)

- ☐ Patient's own request
- ☐ Room entitlement full
- ☐ Room entitlement not available
- ☐ As per room entitlement (Lowest Single Bedroom)
- ☐ Others,.....

PATIENT'S DECLARATION AND AUTHORISATION

Herewith I declare:

1. Knowing, acknowledging and accepting that health insurance benefits have limitations as specified in the insurance policy and will not claim health insurance benefits beyond those specified in the Insurance Policy;
2. Fully responsible for any difference or excess costs to the health facilities that I receive, which facilities excluded in the Insurance Policy;
3. Willing to undergo treatment as a General Patient if the treatment does not comply with the limitations and benefits of the Health Insurance.
4. Giving power of attorney to General Practitioners, Specialists, Hospitals, Clinics, Laboratories, Doctor's Practice with whom I/my wife/husband/child have been examined or treated to provide complete information regarding the condition/disease including a history of previous medical data to PT. AA International Indonesia which has been appointed as a legal third party from My Insurance;
5. Grant permission and power of attorney to PT AA International Indonesia as a legal third party to request, provide, permit, disclose all my medical records and information to insurance, re-insurance, providers and other parties who have records of My health information and related with My Insurance Policy.
6. Hereby release and free each related Party to any legal issues, including but not limited to Civil Lawsuits, Criminal Lawsuits, Complaints and all other legal actions in connection with the granting and/or exercise of this power and permit;
7. I have read, understood and correctly answered the above statements;
8. This power of attorney and permission cannot be cancelled and will continue to apply as long as I live and after I die. Copies/photocopies of this document have the same legal force and are binding in accordance with the original;

Thus I made this Declaration in a conscious state and without pressure or coercion from any party, has permanent legal force, and can be legally accounted for, to be used accordingly.

Signature of Patient: Full Name: Date:	Siganture of Principal: Full Name: Principal ID (KTP/Passport): Relationship to Patient: Date: Contat Number:	Siganture of Witness: Full Name: Witness ID (KTP/Passport): Date: Contact Number:

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