PACIFIC CROSS
HEALTH INSURANCE PCL

MED-SURE SERVICES

ILLNESS & ACCIDENT CLAIM FORM

All sections must be completed by Insured Person / Claimant

1. Insured Person information

1.1 Insured's Name: ………………………………………………………………………………… Age…………….years………… months

1.2 Policy Holder Name (Company Name) ……………………………………………………………………………………………..

1.3 Policy number …………………………………………… Plan ………………………… Member number …………………………………...

1.4 Present address …… Tel. ………………

1.5 In case that you require the company to reimburse the medical expense to your bank account, please state your bank details as below;

Bank Name ……………………………………. Account Name ………………………………Account Number ………………………………

2. In case of Illness **(Physician Attending Summary)**

2.1 Symptoms / Complaint …….

2.2 How long have you been having these symptoms? ……………………………………………………………………………………..

2.3 Have you ever been treated these symptoms before? ☐ No ☐ Yes, if yes, please state hospital's name and address ……………………..

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2.4 When and what treatment kind of treatment did you have? ……………………………………………………………………………

2.4 Diagnosis 1……

2.5 Diagnosis 2 ………...

Signature (...) Date…………………………………………………………

Doctor name………………………………………………………………… Medical Licenses No………………………………………..

3. In case of Accident / Assault **(Physician Attending Summary)**

3.1 Incident Date ……………………….. Time ………………… Place of incident ……………………………………………………………

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3.2 Cause of incident (please describe) ……………………………………………………………………………………………………

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3.3 Have you reported this to the Police ☐ No ☐ Yes, which Police Station ……………………………… Date ………………………

3.4 Details of injury ……….

3.5 Date and place of receiving treatment …………………………………………………………………………………………………….

Signature (...) Date…………………………………………………………

Doctor name………………………………………………………………… Medical Licenses No………………………………………..

I authorize any physician or hospital or any organization that has any records or knowledge of me or my health to disclose to Pacific Cross Health Insurance PCL or its representative any and all information about me with information concerning any medical history and physical condition. A photocopy of this authorization shall be as effective and valid as the original.

……………………………………… Guardians ……………………………………… Insured Person

(…………………………………………) (…………………………………………)

Relationship …………………………………… Date ……………………………………

*** In case of emergency or any queries, please contact 081-452-2597 ***

Pacific Cross Health Insurance PCL, 152 Chartered Square Building, 21st Floor, Room 21-01, North Sathorn Road, Silom, Bangrak, Bangkok 10500

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