CLAIM FORM – INJURY, ILLNESS

PACIFIC CROSS
HEALTH INSURANCE PCL
A member of the Pacific Cross Group of Companies

○ Loss of Life ○ Lose of Organs ○ Temporary Total Disability ○ Permanent and Total Disability
○ Medical Expenses ○ Dentistry ○ Ophthalmology (Vision) ○ Other .....

1 First Name-Surname of the Insured / Authorized person : .....

Sex : ..... Age : ..... Occupation : .....

Address : No. ..... Road ..... Sub-district ..... District ..... Province .....

Tel. : ..... Policy No. : ..... Sum insured : ..... Email Address : .....

2 In case of medical expenses / income compensation while staying in hospital
(Please attach a copy of your bank book with claims documentation)

Transfer to Bank : ..... Branch : .....

Account Name : ..... Account No. : .....

3 In case of illness, please answer the following questions. ○ Out-patient ○ In-patient ○ ICU ○ Other .....

3.1 Hospital Name : ..... Date of Treatment : ...../...../..... (DD / MM / YYYY) Date of Discharge from hospital : ...../...../..... (DD / MM / YYYY)

3.2 Illness : .....

3.3 How long have you had this illness before receiving treatment in hospital? : .....

3.4 Name of Doctor who provided treatment while in hospital : ..... Department Admitted : .....

3.5 Medical Diagnosis : .....

3.6 Treated by ○ Drug use ○ Surgery (specify) ..... ○ Other .....

3.7 Have been examined with the following procedures? :
○ X-ray ○ Heart examination ○ Diagnosis ○ Other (specify) .....

4 In case of injury treatment caused by Accident / Loss of Organs / Temporary Total Disability / Total Permanent Disability please answer the following questions

4.1 Location of Incident : ..... Date of incident : ...../...../..... (DD / MM / YYYY) Time of incident : ...../...../..... (DD / MM / YYYY)

4.2 How did this happen? (Specify) : .....

4.3 Injured organs and description : .....

4.4 Report of incident : ○ No ○ Yes at Police Station ..... Date : .....

4.5 Hospital's Name : ..... Date : .....

4.6 Physician's Name : ..... Department : ..... Date : .....

4.7 Last date of treatment : .....

4.8 Have you been examined for the following procedures? :
○ X-ray ○ Heart examination ○ Diagnosis ○ Other (specify) .....

4.9 Current symptoms or injuries (specify in detail) : .....

5 For women, while admitted to hospital, are you pregnant? : ○ Yes ○ No If yes, Duration ..... Weeks

6 In case of receiving welfare, medical treatment or health insurance with other companies or have co-insurance with other companies, please specify the institution or company name and policy number

Company : ..... Policy No. : .....

I, the signature bearer at the bottom of this Claim Form certifies that I am the authorized person to provide personal information and all of the above statements are true. And I consent to doctors, hospitals, insurance companies, institutional organizations, or anyone with a record of illness or my medical history to disclose all facts to Pacific Cross Health Insurance PCL or the designated person to collect and use to process compensation, consideration Underwriting consideration including the renewal of insurance and I agree that the Company shall disclose the said information to the regulatory agency or the relevant department until the termination of this consent is revoked, In addition, a copy of this consent form shall be considered effective and as complete as the original.

Signed ..... Authorized person

(.....) (Name)

Signed ..... Insured Person

(.....) (Name)

Relationship .....
(Only if the insured is not in a position to claim)

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