

CLAIM FORM – INJURY, ILLNESS



- 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. <input type="radio"/> Out-patient <input type="radio"/> In-patient <input type="radio"/> ICU <input type="radio"/> Other
3.1	Hospital Name : Date of Treatment :/...../..... Date of Discharge :/...../..... <small style="margin-left: 150px;">DD / MM / YYYY</small> <small style="margin-left: 150px;">from hospital</small> <small style="margin-left: 150px;">DD / MM / YYYY</small>
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 <input type="radio"/> Drug use <input type="radio"/> Surgery (specify) <input type="radio"/> Other
3.7	Have been examined with the following procedures? : <input type="radio"/> X-ray <input type="radio"/> Heart examination <input type="radio"/> Diagnosis <input type="radio"/> 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 :/...../..... Time of incident :/...../..... <small style="margin-left: 150px;">DD / MM / YYYY</small> <small style="margin-left: 150px;">DD / MM / YYYY</small>
4.2	How did this happen? (Specify) :
4.3	Injured organs and description :
4.4	Report of incident : <input type="radio"/> No <input type="radio"/> 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? : <input type="radio"/> X-ray <input type="radio"/> Heart examination <input type="radio"/> Diagnosis <input type="radio"/> Other (specify)
4.9	Current symptoms or injuries (specify in detail) :
5	For women, while admitted to hospital, are you pregnant? : <input type="radio"/> Yes <input type="radio"/> 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.

For Group Policy Members Only - Authorization for Claim Payment to Employer

I, hereby, authorize the Insurer to transfer the claim payment for my injury/illness to ("Employer") as my Employer has already paid this claimed amount to me. I authorize my Employer to deal with the Insurer directly in all matters on my behalf. And I willingly forgo my rights to claim for any further expenses related to this injury/illness.

Signed
Insured member

****A copy of your ID card, signed, with the words "True Copy" written above signature is required.****

Signed Insured Person
(.....) (Name)

Signed Insured Person
(.....) (Name)

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