CLAIM FORM - INJURY, ILLNESS



O Los	ss of Life O Lose of Organs O Temporary	Total Disability	
○ Medical Expenses ○ Dentistry ○ Ophthalmology (Vision) ○ Other			
1 First Name-Surname of the Insured / Authorized person:			
	Sex:Occupation:		
	Address: No Road Sub-district	Province	
	Tel.: Policy No.:	ured:Email Address:	
2	2 In case of medical expenses / income compensation while staying in hospital		
۷	(Please attach a copy of your bank book with claims documentation)		
	Transfer to Bank:	′	
		Account No.:	
_			
3		-patient O In-patient O ICU O Other	
3.1	Hospital Name: Date of Treatn	nent:	
3.2	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:		
3.5	Medical Diagnosis:		
3.6	Treated by Orug 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 :		
4.2	How did this happen? (Specify):		
4.3	Injured organs and description:		
4.4	Report of incident: O No Yes at Police Station	Date :	
4.5	Hospital's Name:	Date :	
4.6	Physician's Name: Department	ent : 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 O 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 Oroug Policy Mambara Only, Authorization for Claim Doyment to Forelands			
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 Signed Signed			
this injury/illness. **A copy of your ID card, signed, with (
Signed			
	**************************************	(Only if the insured is not in a position to claim)	

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