PACIFIC CROSS VIETNAM

The strength behind your insurance

NOTIFICATION OF CLAIM FORM

(All sections must be completed)

SECTION A: PARTICULARS OF THE PATIENT

Patient's Name: _____

Policy No.: _____ Member No.: _____

Correspondence Address: _____

Email: _____

Telephone: _____ Fax: _____

SECTION B: AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, insurance company or other medical or medically related facility who has attended me to furnish to insurance company (or its representative) and permit the said insurance company (or its representative) to review any and all information requested with respect to any illness or accident, medical history, consultation, prescription, or treatment and copies of all hospital or medical records and the records of any governmental agency with which a report of any such accident or illness is lodged. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

_____ _____

Date (day/month/year) Signed
(Patient; or Parent if a minor)

SECTION C: STATEMENT BY THE PATIENT (By Parent when Patient is a minor)

1. If as a result of an Accident
   (a) When did the accident occur? _____
   Please state occurrence of the incident _____
   _____
   _____
   (b) Which part(s) of body injured? _____
   _____
2. If as a result of an illness
   When did the symptom first appear? _____
   _____
   _____
3. Payment details
   a. Payment to Policyholder / Insured Person
   Preferred payment method
   - ❑ Cash
   - ❑ Bank Transfer (Please fill in the VND bank details below)

   Account Holder's Name: _____
   Account No.: _____
   Bank Name: _____
   Bank Address: _____
   b. Payment to Medical Provider
   Has direct billing been agreed with **Pacific Cross Vietnam** ? ❑ Yes ❑ No

SECTION D: DECLARATION

I, the undersigned, hereby declare to the best of my knowledge and belief that the particulars stated on this form to be true and correct. I understand that if I fail to provide any information requested in this form, it may result in the inability of the Company to accept or process this claim.

_____ _____

Date (day/month/year) Signed
(Patient; or Parent if a minor)

ATTENDING PHYSICIAN'S REPORT (to be completed by attending physician/surgeon only)

SECTION 1

(a) What was the diagnosis you have made to the conditions of the patient and when was it made?

(b) If confinement in a hospital was required, state diagnosis of condition in respect of which hospitalization was required?

(c) (i) When did the symptom first appear? _____

(ii) When did patient first consult you on this condition? _____

(iii) To the best of your knowledge, has the patient ever had similar conditions or symptoms relating thereto or hospitalized for the same disorders? If "YES", please give dates and details

(iv) To your knowledge, had patient previously consulted any other doctors for these symptoms? If "YES", please give names and address of the doctors

(d) Was the symptom a secondary condition to some other illness(es)? If "YES", please give details

(e) Was the condition caused by or in anyway associated with the conditions mentioned below:

(i) the influence of drugs or alcohol intake?	Yes ❑	No ❑
(ii) AIDS	Yes ❑	No ❑
(iii) infertility or sterilization?	Yes ❑	No ❑
(iv) cosmetic or plastic surgery?	Yes ❑	No ❑
(v) psychiatric and mental disorder?	Yes ❑	No ❑
(vi) congenital deformities or anomalies?	Yes ❑	No ❑
(vii) suicide, insanity or self-inflicted injury?	Yes ❑	No ❑

(f) Are any of the conditions treated due to

(i) accident	Yes ❑	No ❑
(ii) sickness or injury due to patient's employment	Yes ❑	No ❑
(iii) pregnancy	Yes ❑	No ❑

If "YES", state approximate date of commencement of pregnancy _____

SECTION 2

(a) Period of hospitalization?

Admission date: _____

Discharge date: _____

(b) Type of treatment given to the patient:

(c) For surgical or maternity claims

(i) Name and nature of surgical or obstetrical procedure(s): _____

(ii) Date(s) of procedure(s): _____

(d) Discharge summary report:

SECTION 3

Is it possible to provide this treatment on an outpatient basis? If "YES", please give reasons of performing this treatment on an inpatient basis

_____

Signature of Attending Physician with Stamp

Name and Address of Attending Physician

Date (day/month/year)

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