PACIFIC CROSS VIETNAM

The strength behind your insurance

TRAVEL INSURANCE CLAIM FORM

Claim No. (Office use): _____

Please send all claims and inquiries to **Pacific Cross Vietnam**.

A. PARTICULARS OF CLAIMANT

Insurance Certificate No.: _____

Name of Claimant: _____ Date of birth (day/month/year): _____

Postal Address: _____

Passport or Government I.D. No.: _____

Phone No.: _____ Fax No.: _____ Email: _____

B. Please check the appropriate box and submit the required documents as per the claim procedures of the Company.

- ❑ Medical Expenses and Emergency Assistance Benefit (*Please fill out* **Attending Physician's Statement Form** *found at the back)*
- ❑ Hospital Cash Allowance
- ❑ Additional Costs of Travel & Accommodation
- ❑ Family Member Visit
- ❑ Return of Children
- ❑ Personal Accident Benefit
- ❑ Mortal Remain Benefit
- ❑ Baggage and Personal Effect
- ❑ Baggage Delay
- ❑ Loss of Travel Document
- ❑ Personal Money
- ❑ Travel Delay
- ❑ Curtailment of Trip or Cancellation

C. Please give a short description of the circumstances giving rise to your claim (If space is insufficient, please attach additional details.)

Benefit: _____
Details: _____

Benefit: _____
Details: _____

D. OFFICIAL RECEIPTS SUBMITTED (If space is insufficient, please attach additional details.)

Official Receipt Number	Details of Payment *(professional fees, medicines, baggage, etc.)*	Amount *(pls. specify currency)*
	TOTAL	

E. CLAIM PAYMENT DETAILS

- ❑ Cash
- ❑ Bank Transfer (please fill in the VND bank details below)

Account Holder's Name: _____ Account No.: _____

Bank Name: _____

Bank Address: _____

F. AUTHORITY and DECLARATION STATEMENTS

Authority: 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.

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 (Claimant or Parent if a minor)

ATTENDING PHYSICIAN'S STATEMENT

❑ **OUT-PATIENT**
Date of Consultation: _____

❑ **IN-PATIENT**
Date Admitted: _____ Time: _____
Date Discharged: _____ Time: _____

(A) Diagnosis/es	(B) Date when symptoms first	(C) Date of first consultation for the condition	(D) Previous treatment done for the symptom / dianosis	
			Treatment Date	Name of Doctor & Hospital
1.				
2.				
3.				
4.				

(E) If condition is a complication, date when symptoms of its cause started (day/month/year): _____

(F) Name of Surgical Intervention (if any): _____
Any required post-operative consultations? ❑ Yes ❑ No If Yes, specify consultation dates: _____

(G) Any other disease or infirmity affecting present condition? ❑ Yes ❑ No
If yes, please describe: _____

(H) Is condition due to Dental problem, Pregnancy, Childbirth, Miscarriage or Sickness originating there from?
❑ Yes ❑ No If yes, please note the cause: _____

(I) Is the diagnosis in any way related to the ff: congenital/heredo-familial conditions/developmental abnormalities/ birth defects/obesity? ❑ Yes ❑ No

(J) Do you consider this consultation as a continuous treatment for a chronic disease? ❑ Yes ❑ No

(K) Is this a Routine General Medical Examination or Vaccination? ❑ Yes ❑ No

(L) Is this condition accident-related? ❑ Yes ❑ No If yes, when did the accident happen? _____
Around what time: _____ What was the nature of the accident? _____

(M) Is Physiotherapy recommended? ❑ Yes ❑ No

(N) For Out-Patient: Is the condition related to a previous confinement? ❑ Yes ❑ No
If yes, specify confinement date: _____

Hospital: _____
Tel. No.: _____ Fax No.: _____
Address: _____

_____
Signature over Printed Name of the
Main Attending Physician / Surgeon