

The strength behind your insurance

TRAVEL INSURANCE CLAIM FORM

				Claim No.	(Office use):	
Plea	se send all claims and	inquiries to Pacific Cross Vietna	m.			
Α.	PARTICULARS OF	CLAIMANT				
Insu	rance Certificate No.:					
Name of Claimant:					year):	
Post	al Address:					
		I.D. No.:				
Pho	ne No.:	Fax No.:	E1	nail:		
	Please check the ap	opropriate box and submit the	required	documents as per the clai	m procedures of the	
		s and Emergency Assistance		Mortal Remain Benefit		
		out Attending Physician's		Baggage and Personal Effect		
	Statement Form	e •		Baggage Delay		
	 ☐ Hospital Cash Allowance ☐ Additional Costs of Travel & Accommodation ☐ Family Member Visit ☐ Return of Children 			Loss of Travel Document		
			Personal Money			
				•		
			Travel Delay		2 11	
	Personal Accident Benefit			Curtailment of Trip or Cance	ellation	
				nefit:etails:		
D. (OFFICIAL RECEIF	PTS SUBMITTED (If space is in	nsufficie	nt, please attach additional o	letails.)	
	Official Receipt Number	Details of (professional fees, m	of Paymen pedicines, baş	nt ggage, etc.)	Amount (pls. specify currency)	
				TOTAL		
E 4	CLAIM PAYMENT	DETAILS				
<u></u> , \	☐ Cash	22111110				
		(please fill in the VND bank detail	e below)			
		der's Name:	,	Account No:		
		det 8 Ivanie				
	Bank Address					

F. AUTHORITY and DECLARATION STATEMENTS

<u>Authority</u>: 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.

<u>Declaration</u>: 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 PH	HYSICIAN'S STA	TEMENT		
OUT-PATIENT		□ IN-P	PATIENT	_	
ate of Consultation:		Date Admitted:Time:			
		Date Discharged:Time:			
(A) Diagnosis/es	(B) D (1	(C) Date of first consultation for the condition	(D) Previous treatment done for		
	(B) Date when symptoms first		Treatment Date	symptom / dianosis Name of Doctor & Hospital	
				-	
Is the diagnosis in any way a birth defects/obesity? Do you consider this consult is this a Routine General Mark Is this condition accident-result.	Yes No Itation as a continuous Tedical Examination or Plated? Yes No What was	s treatment for a che Vaccination?	aronic disease? Yes No the accident happ	Yes No	
() For Out-Patient: Is the con-			Yes No		
If yes, specify confinement					
		Hos	pital:		
				Fax No.:	
		Tel.	No.:		
	 ame of the	Tel.	No.:	Fax No.:	