CLAIM FORM

SECTION A: DETAILS OF THE INSURED PERSON

(All sections must be completed)

Insured Person's Name: _____

Policy No.: _____ Member No.: _____

Correspondence Address: _____

Email: _____ Telephone: _____

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.

In case I designate an Account Holder's Name to receive the payment of insured benefits that is not the account of the Insured under the Policy, I undertake to: be solely responsible and bear legal risks; undertake not to dispute, claim any content related to the payment by the Company under my appointment under this Claim Form.

_____ _____

Date (day/month/year) Signed

(Insured Person; or Parent if Insured Person is under 18 years old)

SECTION C: STATEMENT BY THE INSURED PERSON (By Parent when Insured Person is under 18 years old)

1. If as a result of an Accident
   - (a) When did the accident occur? _____
   - (b) Where did the accident occur? _____
   - (c) Please describe how the incident occurred _____
   - (d) Which part(s) of the body was injured? _____
   - (e) When was the first doctor visit/ treatment (day/month/year)? _____
   - (f) Where was the first visit/ treatment? (name of hospital/ clinic)? _____
   - (g) Have a police report? Yes ❑ No ❑ . If yes, please provide the police report.
2. If as a result of an illness
   - (a) Name of the disease/ doctor's diagnosis? _____
   - (b) When did the symptom first appear? _____
   - (c) When did you first consult a doctor on this condition (date/month/year)? _____
   - (d) Where was the first visit/ treatment (name of hospital/ clinic)? _____
3. Claims amount: _____
4. Payment details

   Preferred payment method

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

   Account Holder's Name: _____

   Account No.: _____

   Bank Name: _____

   Bank Address: _____

If designating an Account Holder's Name other than the Insured's account, please specify the reason:

_____

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

(Insured Person; or Parent if Insured Person is under 18 years old)

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