INCIDENT REPORT

Name of Insured Person: _____

Policy Number: _____ Member No.: _____

Date of birth: _____

Description:

Time: _____

Date (day/month/year): _____

Place: _____

Occurrence of incident:

_____

_____

_____

_____

_____

_____

_____

Hospital/clinic's name for the first visiting: _____

Date (day/month/year): _____

I, the undersigned, hereby declare to the best of my knowledge and belief that the particulars stated on this report to be true and correct.

I understand that if I fail to provide any information requested in this report, it may result in the inability of the Company to accept or process this claim.

_____ , Date (day/month/year): _____

Declarant

(full name and signature)

Approved/confirmed