PACIFIC CROSS

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: ____________________

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Benefit: ____________________

Details: ____________________

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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: ____________

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Signature over Printed Name of the
Main Attending Physician / Surgeon