HEALTH INSURANCE CLAIM FORM

Pacific Cross Vietnam

A. PARTICULARS OF THE INSURED

Full name: _____ Phone No.: _____

ID/ Passport No.: _____ Policy No.: _____

Email: _____ Member No: _____

B. PARTICULARS OF INSURED EVENT

1. Medical information:

a. Is a result of an illness or an accident?	☐ An illness ☐ An accident
b. Which part(s) of the body was illness/injured?	
c. What is the first symptom? And when did it appear?	
d. Name of disease/doctor's diagnosis?	
e. When did you first consult a doctor on this condition? (date/month/year)	
f. Where was the first visit/treatment? (name of the hospital/clinic)	
g. Have a police report? (for accident)	☐ Yes ☐ No If yes, please provide for us the soft copy

2. Claim amount (VND):

3. Payment method:

☐ Cash

☐ Bank Transfer
(Please fill in the VND bank account details below)

Account Holder's Name: _____

Account No: _____

Bank Name: _____

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

C. DECLARATION STATEMENTS & AUTHORIZATION

I hereby declare that:

1. The answers and information which I given to Hung Vuong Insurance Corporation and its third-party administrator - Pacific Cross Vietnam (hereinafter referred to as "the Company") are true, complete, and correct.

2. I have provided complete and accurate personal information to the Company. I know the type of personal data that will be processed as well as the rights and obligations of the data subject in accordance with the law on protection of personal data. I voluntarily and completely agree and allow the Company to process our personal data for the purposes related to this Claim.

3. Regarding the information and personal data of relevant data subject which I provided to the Company, I warrant that I have the full approval and consent of the data subject to provide the Company and are fully responsible for providing this information and personal data.

4. I do hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Company any such information. A photographic copy of this authorization shall be valid as the original.

5. 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 for and bear legal liability; undertake not to dispute, claim any content related to the payment by the Company under my appointment under this Claim Form.

6. I, the undersigned, 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 (dd/mm/yyyy):

Name and Signature of the Insured
(Parents/Legal guardian sign if the Insured is below 18 years old)

NOTE: Please fully collect and provide to us the claims documents as below:

For examination, treatment in Viet Nam: accept the picture/image/photocopy of claim documents.
For examination, treatment abroad: Required the original paper documents of the Invoice and Receipt.
Other documents can be the copy, scanned or picture.

1. Healthcare insurance claim form with fulfill information and signature. (*) ☐
2. Medical report/medical book/medical summary (*) ☐
3. Doctor's indication note ☐
4. Test result/subclinical result ☐
5. Prescription ☐
6. Discharge certificate/Discharge summary ☐
7. Surgery certificate ☐
8. Oral examination report (for Dental) ☐
9. Treatment plan and progress note complete by physician (for Physical therapy) ☐
10. Invoice/Receipt and relevant Breakdown of charge (*) ☐
11. Incident report (for Accident) ☐
12. Policy report (for Accident, if any) ☐
13. Other related documents ☐

(*) Required documents for all claims.
We will require you to provide more necessary documents depending on each specific situation.