TRAVEL INSURANCE CLAIM FORM

Pacific Cross Vietnam

A. PARTICULARS OF THE INSURED

Full name:

Date of birth (date/month/year):

Passport No.:

Phone No.:

Email:

B. PARTICULARS OF INSURED EVENT

1. Request the claims for:

- ☐ Medical Expenses (*)
- ☐ Emergency Assistance (*)
- ☐ Personal Accident (*)
- ☐ Baggage and Personal effects
- ☐ Baggage Delay
- ☐ Loss of Travel Document
- ☐ Personal Money
- ☐ Travel Delay
- ☐ Curtailment of Trip
- ☐ Other

2. Time and Place of the Insured event:

a. Time (hour/date/month/year):

b. Place:

3. Reasons/Circumstances rise to the Insured event: (please give a short description)

Does it have the police report?

- ☐ No
- ☐ Yes. Please provide us the soft copy.

4. Official receipts submitted (If space is insufficient, please attach additional details.)

Official Receipt Number	Details of Payment (Examination, treatment fee,...)	Amount (please specify currency)
	TOTAL	

5. Claim payment details:

- ☐ Cash (The Amount < 5,000,000 VND)
- ☐ 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:	
REQUIRED DOCUMENTS	OTHER SPECIFIC DOCUMENTS
1. Travel insurance claim form with fulfill information and signature 2. The copy of all pages of the Passport, Visa related to this claim requirement. 3. The copy of the plane ticket, the boarding pass. 4. The invoice, receipt and the corresponding breakdown of charges.	**Medical Expenses:** Medical report and all related documents. **Trip, Baggage, Personal effects & Personal money:** a. Document to prove the value of the damage items b. Confirmation in writing of carrier or other liable parties. c. Incident report verified by the carrier, accommodation facility, police officer d. Other related documents.

- **We will require you to provide more necessary documents depending on each specific situation.**
- **Kindly collect and keep the original copies of all related documents. If your claim is complete, the original documents need to be submitted to the Company to finalize the compensation**

(*) In case of claiming for "Medical Expenses", "Emergency Assistant" and "Personal Accident" benefit, please kindly provide **"Attending Physician's Statement"** on the next page.

D.ATTENDING PHYSICIAN'S STATEMENT

☐ OUT-PATIENT
Date of Consultation:

☐ IN-PATIENT
Admitted Date: Time:
Discharged Date: Time:

Diagnosis	The first symptom date	The first consultation date for the condition	Previous treatment done for the symptom/ diagnosis	
			Treatment Date	Name of Doctor & Hospital

1. If the illness is a complication, please let us know what date it's symptoms started?
Day/month/year:

2. Is there any procedure/surgery done? ☐ Yes ☐ No

3. Is there any post-procedure/surgery visit required? ☐ Yes ☐ No

If yes, please specify the dates of the visit (day/month/year):

4. Is there any disease or other medical issue affect to the current illness? ☐ Yes ☐ No

If yes, please describe:

5. Is the diagnosis in any way related to dental, maternity, miscarriage issue and related conditions?
☐ Yes ☐ No

If yes, please describe:

6. Is the diagnosis in any way related to congenital/heredo-familial conditions/developmental abnormalities/ birth defects/obesity? ☐ Yes ☐ No

If yes, please describe:

7. Do you consider this consultation as a continuous treatment for a chronic disease? ☐ Yes ☐ No

8. Is this a Routine General Medical Examination or Vaccination? ☐ Yes ☐ No

9. Is this illness related to an accident? ☐ Yes ☐ No

If yes, when did the accident happen: Around what time:

What was the nature of the accident?

10. Is Physiotherapy recommended? ☐ Yes ☐ No

11. For Out-patient: Is the illness related to a previous hospitalization? ☐ Yes ☐ No

If yes, please specify the dates of the admission (date/month/year):

CONFIRMATION OF THE MAIN DOCTOR/SURGEON
Signature and Full name

Hospital name:
Tel. No.:
Email:
Address: