

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.

- | | |
|---|--|
| <input type="checkbox"/> Medical Expenses and Emergency Assistance Benefit (<i>Please fill out Attending Physician's Statement Form found at the back</i>) | <input type="checkbox"/> Mortal Remain Benefit |
| <input type="checkbox"/> Hospital Cash Allowance | <input type="checkbox"/> Baggage and Personal Effect |
| <input type="checkbox"/> Additional Costs of Travel & Accommodation | <input type="checkbox"/> Baggage Delay |
| <input type="checkbox"/> Family Member Visit | <input type="checkbox"/> Loss of Travel Document |
| <input type="checkbox"/> Return of Children | <input type="checkbox"/> Personal Money |
| <input type="checkbox"/> Personal Accident Benefit | <input type="checkbox"/> Travel Delay |
| | <input type="checkbox"/> 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: _____

Benefit: _____

Details: _____

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: _____

Signature over Printed Name of the
Main Attending Physician / Surgeon