

## INSURED DETAILS *(to be completed by the insured)*

LAST NAME : ..... FIRST NAME : .....  
FULL ADDRESS *(street, city, postal code, country)* : .....  
TEL NO. : ..... EMAIL ADDRESS : .....@.....  
DATE OF BIRTH : ..... POLICY NUMBER : .....

## CLAIM DETAILS *(to be completed by the insured)*

**BENEFIT TYPE**       **SICKNESS**       **ACCIDENT**

*For sickness only*

Date of first symptoms : .....

New medical condition       Continuing medical condition

*For accident only*

Date of accident : .....

**TREATMENT TYPE**       **OUT PATIENT**       **IN PATIENT**       **PHARMACEUTICALS**

*For in-out patient only*

Date of Consultation 1 : ..... Date of Consultation 2 : .....

General Practitioner       Specialist : .....       X-rays       Laboratory exams  
 Dental Care / Prosthesis       Other Prosthesis / Optical       Medical auxiliaries

*For in-patient only*

Date of admission : ..... Date of discharge : .....

## MEDICAL DETAILS *(to be completed by the Treating Doctor)*

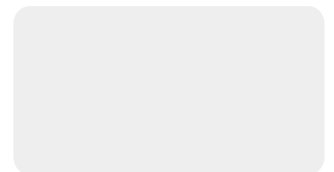
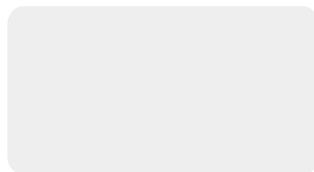
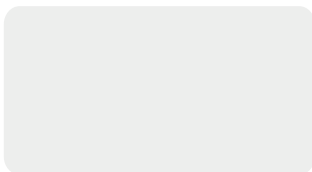
DIAGNOSIS (in full) : .....  
*(Please specify hereafter further details)*

**Medical Certificate attached** *(Please tick the box if a medical certificate is available and put it together with the present claim form)*

**Practitioner Signature**

**Practitioner Stamp**

**Insured Signature**



Date : .....

**TREATING MEDICAL OFFICER (TMO) / REFERRING DOCTOR**

Name : .....  
Tel. : .....  
Fax. : .....  
Email : .....  
Address : .....

**HOSPITAL / MEDICAL FACILITY**

Hospital Name : .....  
Tel. : .....  
Fax. : .....  
Address : .....

## SUPPORTING DOCUMENTS *(to put together with the present Claim Form)*

**Original Invoice(s)**       **Proof of Payment**       **Prescription** (for pharmaceuticals)       **Medical Referral** (for specialist)

**IMPORTANT:** Please ensure to submit ONE CLAIM FORM and all relative supporting documents for EACH and SINGLE DIAGNOSIS. This will greatly assist us in processing your claim. Thank you.