

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.