Claim Form

IMPORTANT INSTRUCTIONS TO COMPLETE YOUR CLAIM:

Complete Sections A and B, and sign Declaration if:

- ► You are claiming only for out-patient doctor visits, medications and general laboratory tests,
- ► The doctor has written the diagnosis on the bill or receipt, or on a separate note, and
- ► You have not been advised you may require surgery, hospitalization, or specialized testing for this disability.

Complete Sections A and B, and ask your Physician to complete Section C if:

- ► You are claiming for in-patient, emergency, or surgical claims, or claims involving complex treatments/tests, accidental injury, or major illness.

SECTION A (To be completed for all claims)

Policy/Member Information

Patient Name	Policyholder Name:
Policy Number:	Member Number:

Contact Details (if different from policy)

Address:		
City:	Country:	Email:
Telephone (home)	Telephone (office)	Fax:

Reimbursement Method

Eligible claims will be reimbursed via bank transfer. Receiving bank charges are the responsibility of the member. Please provide your bank account information below.

Bank Name		
Bank Address:		
Account Name:		Account Number:
Sort Code:	IBAN Code:	BIC (Swift) Code:
Correspondent Bank Details (if applicable):		

SECTION B (To be answered by member or parent if a minor)

If this claim pertains to illness:

When and how did this illness first occur? When did you first consult a doctor about this problem or these symptoms?
Have you ever had a similar illness or symptoms? If yes, please give full details below:

If this claim pertains to an accident:

Date, time, and exact place of accident
Briefly describe how this accident occured:
Was a third party involved? If Yes, please describe their part in this accident, & state whether reimbursement/compensation will be provided.

DECLARATION

I hereby declare that all information provided on this form and the documents submitted herewith is true and correct to the best of my knowledge and belief. The amounts claimed are the actual charges incurred by me, are legally due to me under the terms of this policy, and are not recoverable from any other source.

Authorization for Release of Information

I authorize any doctor, hospital, or other health provider or facility, insuring or reinsuring company, or employer to release to the Insurer ("the Company") any information or records they may have regarding my health, tests or treatments I have received, and benefits or compensation therefor. If this claim relates to an accident, past or present, I also authorize any governmental body, agency, or other person or organization who may have records pertaining to such accident to release such records or information. I understand that this information will be used by the Company to determine eligibility for benefits, and that any information obtained will not be released by the Company to any person except to reinsuring companies or other persons or organization(s) performing business or legal services in connection with my claim, save as may be required by law. I agree that a photocopy or facsimile of this release shall be as effective as the original.

Signature:		Date:	

Signature of Member (Parent if minor)

Claim Form

SECTION C (To be answered by the Attending Physician at the Insured Person's Expense)

Patient Name	Policy /Member Number:

1. State briefly the nature of the illness or injury.

2. When did the symptoms first arise?

3. On what date did the patient first consult you for the condition?

4. Has this patient ever suffered from this condition before?

○ No ○ Yes, Please explain

5. Has the patient ever had any similar condition or related symptoms before this incident

○ No ○ Yes, Please explain

6. is this related to any accident or injury, or in any way connected with the patient's employment or job duties?

○ No ○ Yes, Please explain

7. Please provide full reports including but not limited to past medical history, referral letters, investigative procedures, and treatments:

8. (Claims for surgery) In addition to information in (7) above, please provide name and date of surgical procedure(s), operation notes, pathology report, and discharge summary.

9. (Claims involving pregnancy) Please state approximate commencement date of pregnancy or date of last Menstrual Period:

Attending Physician Name		
Address:		
City:	Country:	Email:
Telephone (home)	Telephone (office)	Fax:

Physician's Signature:		Date:		official Stamp:	

IMPORTANT

- ☐ Have you completed Section A and Section B?
- ☐ Have you signed the Declaration and Authorization for Release of Information?
- ☐ Have you enclosed all original bills, statements, receipts, and any other supporting documents?
- ☐ Has the dentist completed and signed Section C?

Please send completed form and all original bills, statements, receipts, and other documents to:

APRIL Vietnam Company Limited
Unit 201, 2nd Floor, Lafayette Building
8 Phung Khac Khoan Street, Da Kao Ward, District 1 Ho Chi Minh City, Vietnam
Tel: +84 28 7307 7984 | Fax: +84 28 7307 7987
Email: ptics@april.com