บริษัท กรุงเทพประกันภัย จำกัด (มหาชน)
Bangkok Insurance Public Company Limited

Accident and Health Insurance Claim Form

☐ **Hospital Cash Benefit** ☐ **Medical Expense** ☐ **Permanent Disability**
☐ **Critical Illness Medical Expense** ☐ **Permanent Dismemberment** ☐ **Death**

1. Insured's name..... Gender..... Age.....

Identification/Passport Number..... Date of Birth (dd/mm/yy...../..../..... Current Contact Address.....

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Telephone No..... Fax .....Mobile Phone.....

Policy No. ..... Reference No. .....

2. In case of illness, please complete this section. ☐ OPD ☐ IPD ☐ ICU ☐ Others

2.1 Name of Hospital.....Admission Date...../...../..... Discharge Date..../..../.....

2.2 Symptom or Nature of Illness.....

2.3 Duration of the symptom before your first admission.....

2.4 Have you ever received treatment for, or diagnosed of, similar causes of illness, symptoms or diseases earlier? .....

.....

If 'Yes', the hospital name ..... Date...../...../.... ☐ by medication ☐ operation ☐ additional appointment

2.5 Physician's name..... .....

2.6 Diagnosis.....

2.7 Treatment ☐ Medication ☐ Operations, please specify ..... ☐ Others, please specify.....

3. For accidents, in case of death, permanent disability due to physical injuries, permanent dismemberment, or medical treatment, please complete this section.

3.1 Place of Accident..... Date of Accident (dd/mm/yy)...../...../..... Time of accident ....

3.2 Describe and specify cause of the accident.....

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3.3 Witness' Name..... Address..... Telephone No.....

3.4 Injured organs and wounds.....

3.5 Treatment.....

3.6 Hospital name..... Date of treatment ...../...../.....

3.7 Physician's name.....

3.8 Was the accident reported to police? ☐ No ☐ Yes Police station..... Date dd/mm/yy) ..../...../.....

3.9 Date of the last treatment.....

3.10 Did the last treatment include the following? ☐ X-Ray ☐ Heart diagnosis ☐ Blood test ☐ Others, please specify.....

3.11 Please specify and describe in details of current symptom or injury.....

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สท-4-711-56

Personal Accident and Health Claim Team, Bangkok Insurance Plc., 25 Sathon-Tai Road Khwaeng Thung Maha Mek, Khet Sathon, Bangkok 10120.

For additional enquiries, call 0-2285-8888 or Fax 0-2610-2128.

4. For a female, were you pregnant during the admission? ..... Gestational age..... Weeks

5. In case of having welfare or health insurance with other insurers or other co-insurers, please identify names of the institutions or insurance company, and policy number. .....

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6. I would like to receive the claim payment by ☐ Cheque ☐ Bank transfer

Account type: ☐ Savings ☐ Current Bank name ..... Branch .....

Account name ..... Account number.....

*** Please attach a photocopy of the bank book with a verifying signature ***

I hereby certify that all the information given above is true, and authorise any physician, medical practitioner, hospital or clinic, insurance company, organisation, institution or person with my medical record or history, to disclose all particulars, information and documents to the Bangkok Insurance Plc. or any fiduciary. A photocopy of this consent form shall have the full legal enforcement as the original copy.

Signature..... Supplier

(.....)

Date...../...../.....

Signature..... The insured/claimant

(.....)

Date...../...../.....

Relationship to the insured)..... (Only when the insured/claimant cannot make the claim by him/herself.)

Supporting documents

☐ 1. A signature-verified copy of an insurance card

☐ 2. A health insurance claim form

☐ 3. Medical certificate, using the company format

☐ 4. A signature-verified copy of the identification: personal ID card or passport

☐ 5. A police record of the case, signature-verified by the police office / an alcohol report by a forensic institution / A biopsy report (if available)

Additional supporting documents

For a hospital cash benefit claim

☐ Photocopies of receipts, an itemised list of medical expenses, signature-verified by hospital/clinic personnel

For a medical expense claim

☐ Original receipts

For a death claim

☐ Photocopies of an autopsy report and a death certificate

☐ Photocopies of an ID and house registration of the beneficiary

For a critical illness claim

☐ CT scan / X-Ray/ LAB (A biopsy report by a CT scan/X-Ray/LAB)

☐ Other medical history and other diagnosis reports