**CLAIM FORM**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Insurance certificate/Policy No*.*** | | | | |
| **Policyholder** | | | | |
| **Name of Insured person**  (Please write your name correctly as showed on the insurance certificate) | | Tel | | |
| Email | | |
| Male Female | | Date of birth | | |
| ID/Passport No. | | Date joined employer | | |
| ***DESCRIBE YOUR ACCIDENT*** | | ***YOUR DISEASE*** | | |
| Date of accident | | Date of doctor visit or hospitalization | | |
| Date of treatment | |
| Name of hospital or medical facilities | | Name of hospital or medical facilities | | |
| **Types of accident**  Transportation accident  Please provide a copy of valid driving license, vehicle license and the accident report from the recognized Authority/Medical body (if any)  Working accident  Please provide a report of working accident signed by a responsible manager in your working place  Others | | What is the medical diagnosis by your treating doctor? | | |
| Describe your accident | | Was there any previous consultation/treatment / hospitalization for this disease and /or associated conditions or symptoms in this or any other facilities?  Yes  No  If Yes, provide details below. | | |
| Was there any similar or related injury in the past?  Yes  No  If Yes, provide details below. | |
| **Date the insured person first had similar/related injury or became aware of any signs or symptoms for this disease** | **Disease/Symptoms**  (details of treatment/ consultation) | **Name of Hospital/Medical Facilities where insured person received treatment** | | **Health status after treatment** |
|  |  |  | |  |
|  |  |  | |  |
| In case of Death, please send us:  - Death certificate  - Succession certificate (in case of death without leaving a will) | | | | |
| **YOUR MEDICAL EXPENSES** | | Unit: LAK  USD Others:……….. | | |
| 1. | |  | | |
| 2. | |  | | |
| 3. | |  | | |
| 4. | |  | | |
| 5. | |  | | |
| 6. | |  | | |
| Total Sum of Medical expenses: | |  | | |
| **Bank Transferring**  1. Beneficiary | | **Cash**  1. Beneficiary | | |
| 2. Relationship to insured person:  Self Other (please state [clearly)………………………….. | | 2. Relationship to insured person:  Self Other (please state clearly)…………. | | |
| 2. Bank account number | | 2. Passport/ID No. | | |
| 2. Bank name and branch | | 3. Tel | | |
| I declare that the above statements and answers made by me are true and complete to the best of my knowledge.  I hereby authorize any employer, physician, hospital, insurance company or other organization or person who has any record or knowledge with reference to the accident, or the health and medical history of the insured person, to give such information to Lanexang Assurance Public Company (LAP). By signing below, I consent that the personal information collected or held by Lanexang Assurance Public Company (LAP) (whether contained in this form or otherwise obtained) may be used by or disclosed to any individual or organization within or outside of Laos for the purposes of insurance or reinsurance related business including claims processing, investigation, account collection and litigation.  A photocopy of this authorization will be as valid as the original. | | | | |
| **Signature of Policyholder**  (Signed and stamped) | | | **Signature of Claimant** | |
| Full name | | | Full name | |
| Date | | | Date | |