CLAIM FORM

(Please fulfill required information and
send it back to PVI Insurance right after treatment ends)

A. Personal information of the Claimant

Name of the claimant:

Relationship with Insured:

Address:

Tel. No: E-mail:

B. Insured's information

Insured Name: Sex: □ Male □ Female

ID card No: Date of Birth:

Policyholder:

Policy No. / PVI Health Ins. Card No.:

C. Treatment information

Date of visit or Date of accident:

Place of accident:

Medical conditions or Diagnosis/Cause of accident:

Consequence:

Type of treatment: □ Out-patient □ In-patient – from to

D. Payment Information

Information		**Payment Request** **Beneficiary Information**
1. Total amount claimed:	...	□ Cash □ Bank transfer Beneficiary: Account No: Bank name: Bank address:
2. In case of:	□ Death □ Disability □ Medical expenses □ Emergency evacuation □ Allowance	

E. Declaration and Authorization

I, claimant, hereby declare that the above information is correct and sufficient to the best of my knowledge and belief. I bear full responsibility before the law if there is any deviation of information notified and any dispute about the right to enjoy the money.

I also understand that this declaration gives permission to PVI Insurance and their appointed representatives to approach any third party for information required to complete their assessment of this claim including, but not limited to, current and previous Medical Practitioners.

……, date……/……/……

Confirmed

(Signature and stamp of Policyholder or Government office, Police where the accident happened)

Claimant

(Signature of the Claimant)