Outpatient (OPD) and Accident Claim Form

Hospital Name..... Company Name.....

☐ Individual Insurance ☐ Group Insurance

Part A

For Insured

1. Name-Surname of the Insured: ..... Gender: □ Male □ Female ID Card No.: .....
   Date of Birth: ..... Age: ..... Years ..... Months .....Occupation: .....
   Mobile Phone No.: .....Tel.: ..... Email: .....
   Current Address: .....
2. Policy No.: .....
   Do you have insurance policy with other companies? □ No □ Yes
   1. Company: .....Policy No.: .....
   2. Company: .....Policy No.: .....

I allow and give consent to doctors, medical centers, other insurance companies or related persons who have my personal data, health information, disability, sexual behaviors, biological data, race, religion (if any) and health record, both at present and in the future, to disclose such information to the Company, the Company's life insurance agents, or the Company's representatives or insurance brokers or policyholders for the purposes of insurance application or policy benefit payment or any operations regarding insurance policies.

I give consent to the Company to collect, use and disclose my personal data, health information, disability, sexual behaviors, biological data, race, religion (if any) and health record to agencies in authorities or reinsurance brokers or reinsurance companies, related persons, the Company's life insurance agents, personnel or representatives of the Company, or policyholders and/or insurance brokers for the purposes of insurance application or policy benefit payment or medical benefits or any operations regarding insurance policies.

In case of claiming through the hospital, I agree that the Company pays for the medical expenses to the medical centers where I have received this treatment and it should be deemed that the Company has duly paid medical expenses to me in accordance with the terms and conditions of the insurance policy. However, if there are any medical expenses that are outside the coverage of the insurance policy, I will pay directly to the hospital and I fully understand that the Company reserves the right according to the fax claim/credit claim agreement or other applicable agreements if it is found that my illness or accident is under the exclusion of the insurance policy even though the Company has accepted the inpatient hospitalization. In this case, if the Company has already made the advance payment to the hospital on my behalf, I agree to return all payments to the Company within 7 days of receiving notice from the Company.

In this regard, a copy of the consent letter shall have the same effect as the original.

I have acknowledged and understand the messages, terms and conditions of the Company under this document very well in detail. I agree that it is correct according to my intent. In this regard, I hereby agree to be bound by the conditions and practices of the Company in all respects. I have acknowledged the Privacy Policy of Muang Thai Life Assurance Public Company Limited, and I therefore agree to give consent.

Remarks:

Scan here "Privacy Policy"

* In case of a minor, a parent is required to sign and specify the relationship.
* In case the insured is a minor aged over 10 years but less than 20 years, a father/mother/legal guardian must sign together with the minor and specify the relationship.
* In case of signing by fingerprint, signatures of 2 witnesses must be completely provided.

Insured: ..... Date: ..... Witness: ..... Witness: .....
(.....) Relationship: ..... (.....) (.....)

Grantor: ..... as a ☐ Father/Mother

☐ Legal representative of the insured (in case the insured is a minor)

For Hospital

1. Visit date: ..... Time: ..... Vital signs: T : ..... P : ..... R : ..... BP : .....
2. Chief complaint and duration: .....
3. Present illness or cause of injury: .....
   .....
   .....
4. An accident; Date of accident: ..... Time: .....
   Place.....
5. Physical exam: .....
   .....
6. Is the illness related to : (please tick ☑ if yes)
   - ☐ Pregnancy / Childbirth / Infertility / Caesarean section / Miscarriage
   - ☐ Congenital / Hereditary disease
   - ☐ Nervous / Mental / Emotional / Sleeping disorder
   - ☐ Influence of Drugs / Alcohol
   - ☐ Cosmetic reason / Dental care / Refractive errors correction
   - ☐ AIDS
7. Underlying condition: .....
8. Diagnosis: .....
9. Investigation & Result (Lab, EKG, X – ray, etc.).....
10. Treatment
    .....
    .....

Physician's Name ..... Medical License No. ..... Specialty .....

(.....) Date .....

Remark: A physician who issues this report must be licensed to practice medicine and duly registered [KS1]by the Thai Medical Council.