CLAIM FORM – GROUP PERSONAL ACCIDENT

Please send the completed Claim Form, as soon as possible, to your insurance advisor or broker or to:

Claims Department QBE Insurance (Vietnam) Ltd Suite 1302 A The Metropolitan, 235 Dong Khoi St, Dist 1, HCMC Vietnam

Tel: + 848 38245050 Fax: + 844 38245054 Hanoi Branch Room 701, North Star Building, No 4 Da Tuong, Hoan Kiem District, Hanoi Vietnam

Tel: + 844 3942 8668 Fax: + 844 3942 8669

CLARATION
Policy Number:
Email:
Age
Position
Last working day (in case of death)
ID Number:
Mobile number:
Place of Accident:
Date of discharge:
-
Email:

MEDICAL EXPENSE

Required documentation

- a) Medical report/ Doctor Prescription/ Doctor Note
- b) Receipts/invoices of medical expenses incurred (original)
- c) Itemized hospital bills (if hospitalized) and Discharge slip/memo from attending physician if there's hospitalization
- d) Medical record and relevant test result (if any)
- e) Vehicle registration and Driving license (if traffic accident)

Item	Invoice No	Doctor	's note	Amount
	nem	invoice No	Yes	No

<u> </u>	1									
Total										
	l l									
Amount claimed for weekly	benefit:	c Days =								
Required documentation for										
	Medical Report including doctor's prescription on number of days off work									
c) Copy of the salary slip (i.e. based on last drawn salary)										
DEATH AND PERMANENT D	ISABILITY									
Required documentation										
a) Police Report or releb) Death Certificate	·									
c) Autopsy report,										
e) Vehicle registration a	and the second of the second o									
Date of Death:		. Time:								
Has autopsy service done?		☐ Yes	□ No							
• •										
· •										
•			ationship with Deceased							
	= '									
PERMANENT DISABILITY										
Required documentation a) Medical Record										
a) Medical Recordb) Permanent Disability	Certificate									
	ant authority report									
·	n of how the accident oc	curred and the injuri	es sustained							
e) Vehicle registration a	nd Driving license (if tra	ffic accident)								
Date of accident:		Date disability v	vas confirmed:							
Date of accident:										
	<u>-</u>									
,										
Total Amount Claimed	PAYMENT IN	IFORMATION (Pleas	e transfer settlement to my bank acc	count)						
	Name:									
	Account nun	nber (VND) :								
	Bank name									
	Bank IFS Cod Bank address									

CLAIMANT AUTHORISATION

I hereby authorize any hospital doctor or other person who has attended me to furnish QBE Insurance (Vietnam) Co., Ltd or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all hospital or medical records. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

Name and signature of claimant

Confirmation of policy holder/ Employer

VNM_EN_FORM_CLM_ GPA v 1.0