BANGKOKLIFE ASSURANCE

Form OPD&IPD (Illness & Accident)

Part 1 information of Insured person

Name-Surname..... Date of birth ..... Age..... Sex ..... Personal No. ….....

Present address..... Phone no. .....

Policy No. ..... Passport No …..... Nationality ….....

Are you eligible for compensation from other company? ( ) Yes, please specify …..... ( ) No

In case of accident

Date of accident ..... Time ..... Any policy report ( ) Yes, please specify ..... ( ) No

Cause of accident .....

Admission date …..... Discharged date …..... Room No …..... HN …..... AN .....

In case of illness

Admission date …..... Discharged date ….....

I hereby permit and agree Bangkok Life Assurance Public Company Limited advance eligible medical expenses for the specified hospital in accordance with the benefits schedule. However, should at a later date it be proven that I am not eligible for medical benefits coverage, I agree to reimburse Bangkok Life Assurance Public Company Limited for the claims paid within 7 days of receiving notice. Also should I be eligible for medical benefits coverage from other insurance policies then I agree for the medical expenses to be shared between those insurance policies as well. Should the medical expenses be in excess of my insurance coverage then I agree to pay for the excess.

I hereby authorize any hospital or physician or third party who has rendered care to notify Bangkok Life Assurance and reveal all information requested regarding to any illness or accident, past and recent medical history, or medical treatment to Bangkok Life Assurance. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Insured Person ..... Date ..... Signature of witness ..... Date .....

(.....) (.....)

Remark In case of signing by fingerprint, signatures of witness must be completely provided.

Part 2 for Attending Physician only

( ) OPD ( ) IPD (Part I for Admission)

Physician's name …..... Medical specialty …..... Medical License no .....

Patient's name..... HN. ..... AN. .....

1. Visit date ..... Time .....

2. Vital signs T:..... BP:..... P:..... R:.....

3. Chief complaint / duration .....

4. Present illness or Cause of injury .....

5.Previous treatment for this illness or injury (Date & Place) .....

6.The illness directly related to an accident : ( ) No ( ) Yes, Date of Injury: ..... Time .....

7. The illness or injury influenced by alcohol or drug addict: ( ) No ( ) Yes, please specify .....

8. Past History / Underlying disease: .....

9. Provisional diagnosis: .....

10. Physical examination: .....

11. Treatment & Medication: .....

12. Any other comments / appointment / working leave / rest .....

13. For IPD

Indication for admission: .....

Plan of Treatment: .....

Expected length of stay ..... Day(s)

Signature of Attending Physician ..... Date ..... Hospital: .....

(*Hospital stamp*)