



**Prudential Life Assurance (Thailand) Public Company Limited**

9/9 @Sathorn Building, 21<sup>st</sup>-27<sup>th</sup> Floor, South Sathorn Rd., Yannawa, Sathorn, Bangkok 10120

Customer Service Tel. 1621 Email: hotline@prudential.co.th Website: www.prudential.co.th

Registration and Tax Identification No. 0107537001897

**Living Claim Form**

- Accident / Personal accident
- Hospital surgical (HS)
- Hospital income
- Others .....

Please fill in full details and submit together with a copy of ID card

Additional supporting claim documents required for HS claims

1. Physician report or Diagnosis report
2. Original receipt and expenses summary statement

1. Insured's name ..... Age ..... Policy No. ....  
 Payor's name ..... Age .....  
 Residential address ..... Tel. ....  
 Office address ..... Tel. ....
2. a) Claim cheque to be sent to  Residence  Office  
 Others Please specify.....  
 b) If the insured lives up-country, please state bank account details .....
3. For accident claim  
 Incident date ..... Time ..... Place of accident .....  
 How did the accident happened?..... Witness's name and address .....  
 Report to police or not, please specify .....  
 Organs injured ..... wound details .....
4. For Hospitalization claim  
 Diagnosis ..... Since when .....  
 Symptoms..... Result of treatment .....
5. Hospital ..... Physician's name .....
6. Do you have insurance with other companies ? ..... If yes, please specify Company's name.....  
 Policy No. ....

Remark : If you have enquiries, please contact agent / branch office or Customer Service Center. Tel.0 2353 4999.

I, hereby, certify that the above-mentioned statement is true and correct, and there is no material information I omit to disclose to the Company

I hereby authorize any hospital physician or other person who had attended or examined me, to furnish to the Company or Authorized Representative, any and all information with respect to any sickness or injury, medical history, consultation prescriptions or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

(Signed) ..... Insured  
Date .....



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**Physician's Report**

**Patient's Name** ..... **Age:** ..... **years Sex:**  male  female

**ID No** ..... **H.N.#** ..... **A.N.#** ..... **X.N.#** .....

**Date admitted** ..... **Time** ..... **Date discharged** ..... **Time** .....

1. CHIEF COMPLAINT :  
.....

2. FOR ILLNES  
a) How long had the patient experienced the symptoms? ..... days / weeks / years.  
b) How long do you feel that symptoms existed prior to this consultation? ..... days / weeks / years.  
c) Did you advise the patient to be admitted to the hospital?  No  Yes  
Indication for admission .....

3. FOR ACCIDENT  
a) Date & time of accident : Date : ..... Time : .....  
b) Cause of accident : .....  
c) Was the patient under the influence of alcohol or drug at the time of arrival to the hospital?  No  Yes .....

4. Date first saw the patient for this illness / injury : .....

5. a) Present illness / Details of Injury : .....  
b) Pertinent clinical findings (symptoms & signs) .....

6. a) Pertinent lab / Investigations : .....  
b) HIV Test  Yes, result .....  No

7. Diagnosis 1 ..... ICD 10  Diagnosis 2 ..... ICD 10   
Diagnosis 3 ..... ICD 10  Diagnosis 4 ..... ICD 10   
( Including principle underlying condition and complication )

8. a) Treatments (including number of stitches, medication given, physiotherapy, etc.) :  
.....  
b) Operation : ..... ICD 9  Pathology report : .....  
Surgeon's Name ..... Specialty ..... Date performed : .....  
c) Diagnosis and treatment by other doctors in the same occasion.  No  Yes ,please give detail  
.....

9. a) Result of Treatment :  Good  Fair  Poor  
b) Possibility of recurrence?  Yes  No

10. a) Date of the last treatment / Follow up : .....  
The patient's symptoms at the time of your last consultations / examination? .....

11. Was the patient referred to you by other physician(s)?  Yes  No  
Doctor : ..... Clinic / Hospital : .....

Warning message:  
In the event that a medical practitioner makes false statements which may cause damages to others or the public, it shall be deemed that the person commits criminal offence according to the Criminal Code and must be punished with imprisonment not exceeding two years or fine not exceeding 4,000 baht, or both, and must also be subject to civil liability.



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12. Was the injury / illness contributed to or influenced by any of the following (eg: Pre-existing weakness or extended period of disability)?

- a) Physical defects / congenital anomaly  No  Yes
- b) Unfavorable past medical history  No  Yes
- c) Degenerative change(s)  No  Yes
- d) A family history that increased the probability or severity of this disease  No  Yes
- e) Doctor's advice to have periodic "Medical Screening" for this disease because of increased risk?  No  Yes
- f) Alcohol or drugs = ..... mg%  No  Yes

If the answer is "yes", please specify

.....  
 .....

13. Other past medical history :

Date	Diagnosis	Treatment	Duration	Doctor / Hospital's / Name
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....

14. FOR FEMALE : Was the patient pregnant at the time of treatment  No  Yes ..... weeks ( LMP: ..... )  
 : Was the treatment relate to infertility?  No  Yes .....

15. Other comments about the injury / illness

.....  
 .....

**I, hereby certify that I have personally examined and treated the insured in connection to the above disability and that the facts are in my opinion as given above.**

**Name of physician** ..... **Specialty** ..... **License No.** .....

**Hospital Name** ..... **address** ..... **TEL No.** .....

**Signature** ..... **Date** .....