Allianz AYUDHYA

# Personal accident Claim form

**Please complete clearly in BLOCK CAPITALS.**

One form must be completed for each claimant.

Further information about how to complete this form can be found on the reverse.

**Failure to complete all sections marked 'must be completed' on this form may result in delays.**

## Section A: Claimant details – must be completed

| | |
|---|---|
| Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms | Other: |
| Family name (surname): | First name(s): |
| Date of birth (dd/mm/yyyy): | Sex: ☐ Male ☐ Female |
| Member number: | Plan number: |
| Correspondence address: | |
| Town: | Postcode: Country: |
| Email: | |
| Daytime phone: | Evening phone: |

## Section B: Main member details (if different from section A)

| | |
|---|---|
| Family name (surname): | First name(s): |
| Member number: | Plan number: |

## Section C: In the event of a claim arising from an accident resulting in death

### Entitled beneficiary details

| | |
|---|---|
| Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms | Other: |
| Family name (surname): | First name(s): |
| Date of birth (dd/mm/yyyy): | Sex: ☐ Male ☐ Female |
| Correspondence address: | |
| Town: | Postcode: Country: |
| Email: | |
| Daytime phone: | Evening phone: |

Provide proof you are entitled to claim for such fund under the planholder's Personal accident plan.

## Section D: Claim details

Specify under which section of the Personal accident plan you are claiming.

## Section E: Data Protection and Declaration – the Declaration must be signed by the claimant or the main member or the entitled beneficiary if the claimant is a dependant under the age of 20

### Data Protection Notice

We are committed to protecting your personal data and privacy. Any personal information that we collect from you will be kept confidential and will be processed in accordance with relevant legislation and our own strict internal policy.

We will use any personal data to process your claims, administer your plan, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

Your information may also be used for the detection and prevention of fraud and for audit purposes. If you give us false or inaccurate information and we suspect fraud, we will record this. We may pass such information to Law enforcement and other legal agencies, governmental or judicial bodies, or to regulators.

If you want us to disclose your medical information to another individual or next of kin, you must tell us. In exceptional emergency situations, and in accordance with medical confidentiality guidelines and relevant law, we may be required to disclose such information to relatives, family members or other third parties.

We will communicate directly with you about your claim if you are aged 20 or over, or with the main member if you are under 20 unless we are advised otherwise. Claims information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information, or to another person that you have authorised us to provide such information.

If you want us to disclose your medical information to another individual or next of kin, please complete the section below.

I would like information about this claim to be provided to:

| **Name:** | **Relationship:** |
|---|---|

### Declaration

I declare that all the details given on this Claim form are true and accurate and that I have not missed out any details important to this claim. I understand that if this claim is found to be fraudulent, in whole or part, I may be committing a criminal offence and that this may invalidate the plan. I authorise any medical practitioner, specialist, therapist or other relevant establishment who has attended me/the patient in the past, or is attending me/the patient at present, to give any details that may be asked for by the insurer or its duly appointed administrators or authorised agents.

I confirm that I give explicit consent (on behalf of myself and any family members specified in this form) for the insurer or its duly appointed administrators or authorised agents to process our personal information with respect to our membership and I confirm that I have brought this Data Protection Notice to the attention of these family members.

I authorise and request any hospital, specialist, physician or other health provider to furnish the insurer or its duly appointed administrators or authorised agents with such information as they may seek from them in connection with any treatment or other services provided to me or my dependant/s for the purpose of the consideration of this claim.

| **Patient's/main member's signature:** | **Date (dd/mm/yyyy):** |
|---|---|

## Section F: Accident details

Date of accident (dd/mm/yyyy):

Time of accident:

Place of accident:

Full description of accident:

Use a separate document if you need mor e space to describe the accident.

What injuries did you sustain?

Have you ever had any previous medical conditions relating to this part of your body? ☐ Yes ☐ No

If 'Yes', please give details:

Is this injury a result of a road traffic accident? ☐ Yes ☐ No

Was the road traffic accident reported to the police? ☐ Yes ☐ No

If 'Yes', send us a copy of the police report.

Is there a pending prosecution against you? ☐ Yes ☐ No

Is this an injury that happened in your workplace? ☐ Yes ☐ No

If 'Yes', pr ovide your employee contact details on a separate document.

Give the name(s) and address(es) of every doctor consulted for the present injury, including your medical practitioner/specialist.

Name of medical practitioner/specialist:

Qualifications:

Address:

Telephone number:

Email:

## Section G: Treating doctor's statement – must be completed by the treating doctor to avoid delays in assessing the claim

Name of claimant:

Date of accident (dd/mm/yyyy):

Are you the claimant's usual medical practitioner? ☐ Yes ☐ No

Is the claimant's disability due solely to this accident? ☐ Yes ☐ No

Accident details, including the cause:

Is there any indication that alcohol or other intoxicating substance was a contributory factor to the accident? ☐ Yes ☐ No

Has the accident resulted in the claimant's death? ☐ Yes ☐ No

**If 'Yes', the questions below do not need to be responded to. Please sign the declaration at the bottom of this section.**

If the injury sustained involves an eye or limb please state left or right: ☐ Left ☐ Right

Diagnosis:

Treatment:

Was a surgical procedure performed? ☐ Yes ☐ No

If 'Yes', give details, including date(s) :

## Section G: Treating doctor's statement (continued)

Were any fractures sustained? ☐ Yes ☐ No

If 'Yes', confirm site of fractures:

Is there any evidence of bone disease or osteoporosis? ☐ Yes ☐ No

If 'Yes', confirm date diagnosed (dd/mm/yyyy)

Has the claimant suffered a third degree burn? ☐ Yes ☐ No

If 'Yes', provide details about the area of burns. Give your assessment of the percentage of body surface which has been affected by third degree burns by reference to the 'Rule of Nines'.

At the time of the accident, was the claimant suffering from any other sickness or disease? ☐ Yes ☐ No

If 'Yes', give details with medication prescribed and advise whether this will delay recovery of present disability:

Has the claimant previously suffered this type of injury? ☐ Yes ☐ No

If 'Yes', give details, including date(s):

Is the claimant suffering from any other medical condition or disability which is affecting their recovery? ☐ Yes ☐ No

If 'Yes', please specify:

In your opinion, do you think the claimant will be left with a permanent disability solely as a result of the accident? ☐ Yes ☐ No

If 'Yes', give full details (including whether it is partial or total disability, treatment and medication).

## Declaration

I declare that to the best of my knowledge and belief the information I have given in this section of the Claim form is full, true and complete.

| Medical practitioner's/specialist's signature: | Practice stamp: |
| --- | --- |
| Date (dd/mm/yyyy): | |

## Section H: Payment details – must be completed

We will only issue payment to:

- the claimant if they are 20 or over;
- the planholder if the claimant is under 20 and is a dependant under the plan; or
- the entitled beneficiary in the event of the planholder' s death.

Failure to complete all information for the chosen payment method may result in you, the named person or entity:

- experiencing delays in receiving the claim settlement; and
- incurring additional bank charges.

Name of account holder:

**If the claimant's name (as given in section A) is different to the account holder name, please provide the following details:**

Address of account holder:

Email address of account holder:

Telephone number of account holder:

**Bank account details:**

Bank name:

Bank address (including town and city):

BIC/SWIFT code:

Currency of bank account:

Account number:

To help us direct your payments efficiently, supply the following as relevant:

IBAN number (mandatory for all payments to bank accounts in countries that have adopted IBAN):

Sort code (mandatory for UK located banks):

Routing code/Branch code (as available)

ABA number (mandatory for transfers to US located banks):

## Important information

Please remember these important points when completing your Claim form:

- Assessment of your claim may be delayed if you and the medical practitioner/treating doctor do not complete all the necessary sections of this form.
- Send your claim to us as soon as possible. We recommend that you do so within a maximum period of six (6) months of the accident date.

Make sure that you complete sections A-F and H, and that all the relevant doctors complete section G.

## Section E and G

- If the declarations have not been read and signed, we will not be able to process your claim.

## Section H – Payment details

i. Ensure that you are able to receive payment in the currency you have requested.

ii. We reserve the right to pass on any payment charges incurred by us for cancelling the original payment due to inaccurate information submitted to us.

iii. We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or bank service charges. Please contact your bank for further details .

iv. If you do not give us the sort code/routing code, BIC/SWIFT code and/or IBAN number, you may incur additional bank charges and it will result in a delay in us paying your claim. You can find the payment information on your bank statement.

v. We can make payment in most readily traded currencies and to most countries. In the event that we are unable to make payment in the currency or to the country you have specified, we will contact you to confirm an alternative currency. If you do not specify a payment currency, we will pay your claim in the currency of your plan. For the current list of applicable currencies and countries please refer to our website.

vi. Your bank may ask you to complete additional paperwork before they can release our payment to you. This may delay your receipt of the payment and is outside our control.

## Checklist

**Please send your claim to us by post. Please check you have included:**

- **a fully completed Claim form with signed and dated declarations** ☐
- **an original Police report if relevant** ☐
- **where relevant, proof you are entitled to claim for such fund under the planholder's Personal accident plan if you are the entitled beneficiary** ☐
- **other relevant documentation** ☐

**Photocopies, receipts and credit card statements are not acceptable.**
**We are unable to return original documents, but are happy to provide certified copies on request.**

- **an original hospital admission and discharge form if claiming hospital cash benefit** ☐

**Please call us on +66 (2) 662 8280 press 4 or email th-claims@aetna.co.th if you require any further assistance.**

Send your claim to: IPMI Claims Team, Allianz Ayudhya General Insurance Public Company Limited.
898 Ploenchit Tower, Ploenchit Road, Khwang Lumpini, Khet Pathumwan, Bangkok 10330
T +66 (2) 662 8280 press 4  Office hours: 08.30-17.30