# Claims Form
(V.03)

## Important Notes:

- To assist us in processing this claim accurately and speedily, please complete this form fully, clearly and legibly.
- Please complete this form in English.
- All claims must be submitted within 60 days of the start of treatment.
- Please attach all original invoices, retaining photocopies for your own reference.
- A separate claims form should be used for each patient and each medical condition.
- Processing of this claim may be delayed if the information provided is incomplete.

Please email this completed claims form to claims@ulinkmyanmar.com, along with:

1. Receipts / invoices
2. Medical certificates / memo / booklet
3. Lab test results and all other medical reports

## SECTION A – Patient's Details

| | | | |
|---|---|---|---|
| **Policyholder Name** (according to NIRC/passport): | Zaw Zaw Naing | | |
| **Policy Number:** | 25000000AAA000 | | |
| **Claimant's Title:** | Mr./Mrs./Ms. | | |
| **Claimant Name** (according to NIRC/passport): | Zaw Zaw Naing | Relation to policyholder | Self/dependent |
| **Date of Birth:** | 0 1 / 0 1 / 2 0 | | |
| **Contact Number** | | | |
| **Email Address:** | Zaw@gmail.com | | |

## SECTION B – Details of illness / Injury

Please describe the nature of your illness / injury:

Fever

Please provide details on the treatment received:

| Date of Treatment dd/mm/yyyy | Place of Treatment | Fully description of treatment | Diagnosis | Treatment Charges & Currency | In-patient / Out-patient / Dental / Optical |
|---|---|---|---|---|---|
| E.g. 01/09/2019 | Asia Royal Hospital | Painkiller | Fever | 20,000 MMK | Outpatient |
| E.g. 01/08/2019 | IQ Vision | Eyedrops | Eye Infection | 100,000 MMK | Optical |
| | | | | | |
| | | | | | |

Date of First Symptoms: 0 1 / 0 1 / 2 0

Date of First Medical Consultation: 0 1 0 1 2 0

**Important Declaration:**

| | Yes | No |
|---|---|---|
| 1. Is the claim related to in-patient treatment? | ☐ | ☐ |
| 2. Does the claim relate to pregnancy or maternity?<br>If **yes**, the expected delivery date is: 01/01/2019 | ☐ | ☐ |
| 3a. Does the claim relate to an accident? | ☐ | ☐ |
| If **yes**, please provide details of incident names, addresses and telephone numbers of any third parties and witnesses involved:<br><br>If the accident was reported to the police, please provide the report date, the report number and the police station details: | | |
| 4. Is the claim amount more than USD 1,000 or MMK 1,500,000? | ☐ | ☐ |
| 5. Is the claim for treatment outside Myanmar? | ☐ | ☐ |

## SECTION C – Bank Details

Please provide your bank details below. If approved, the claim will be settled by direct bank transfer. (Direct bank transfers are available only for CB Bank account holders and KBZ Bank account holders.)

| | |
|---|---|
| **Your provided bank account details are not changed.** | **Yes** ☐ **No** ☑<br><br>If **yes**, please skip this section.<br>If **no,** please proceed to fill in your new bank details as per below: |
| **Name of Bank:** | |
| **Address of Bank:** | |
| **Name of Account Holder:** | |
| **Account Number:** | |

## SECTION D – Declaration

I/We confirm the facts stated on this form to be true and accurate to the best of my/our knowledge.

I/We have provided all the necessary documents to process this claim.

I/We give authority to the insurers and their representatives to contact my/our medical practitioners for further clarification (if required) on the documents submitted by me.

| | |
|---|---|
| **Signed:** | |
| **Print Name:** | Zaw Zaw Naing |
| **Date:** | 1.9.2019 |

**Please email this form to claims@ulinkmyanmar.com**