MEDICAL INSURANCE CLAIM FORM

The Insured Member is required to furnish the following documents to his/her Insurance Representative or Ulink Assist when making a claim:

1) Completed medical insurance claim form
2) Originals of all relevant documents and final detailed hospital/ doctor's bills and receipts inpatient discharge summary (if applicable)
3) Use a new Claim Form for each separate illness or injury

Ulink Assist (Co. Reg.: 20FC)
Tel: 0966 110 8822
Email: ulink@mhcasia.com
Address: #16-09, Office Tower 2,
Times City. Hanthawaddy Road,
Kamayut Township, Yangon

Please tick the appropriate box. Kindly advise us if you are claiming for benefits under:

☐ Dental ☐ Maternity ☐ Wellness/ Preventive Medicine ☐ Health Screen ☐ Outpatient ☐ Inpatient ☐ Others:

SECTION A: TO BE COMPLETED BY POLICYHOLDER **POLICY NO:** _____.

1) Name of Policyholder	NRIC/Passport No	Date of Birth	Gender	Marital Status	Occupation/ Company name
2) Name of Patient (if other than Policyholder)	NRIC/Passport No	Date of Birth	Gender:	Marital Status	Relationship to Policyholder
3) Present Address			4) Contact No:		5) Email:

DETAILS OF ILLNESS/ INJURY

6) Is this treatment recommended or referred by physician or surgeon? Name of Referring Physician/Surgeon: Address of Referring Physician/Surgeon:	☐ Yes ☐ No If Yes, please state:
7) Sickness a) Date First Begin	b) Describe Nature of Sickness and Operation
8) Accident a) Date/Time of Accident	b) Describe How and When Accident Happened
9) Treatment a) Date first Treated	b) Name & Address of doctor first consulted for the sickness or injury? c) Name & Address of doctors/ specialist attended to the patient during hospital confinement?

10) a) Date of Admission	b) Date of Discharge	c) Date of Operation, if any
11) Is the patient presently also insured for medical under another insurance company? If Yes, please state	☐ Yes	☐ No b) Policy No

12) **SETTLEMENT OPTION**

Please complete the section below for bank accounts in Myanmar. For bank accounts outside of Myanmar, please complete the section under **Annex 1** for approval.

a) Name of Account Holder: b) NRIC/Passport No c) Contact No:

d) Bank Name: e) Branch Name f) Account No:

NOTE: For CB Bank Account Holders, claim will be paid via i-banking. For non-CB banks, claim will be paid via cheque. For cheque payment, please tick your referred settlement mode: ☐ Mail to the Policyholder member, please provide mailing address ☐ Pick up from Ulink Assist office ☐ Drop into Policyholder's bank account

DECLARATION & AUTHORISATION (This part must be signed by the patient or patient's parent/legal guardian if the patient is below 21yrs of age)

I_____ NRIC No: _____ hereby authorise Ulink Assist to request from any hospital, physician, person or organisation, all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records concerning the patient at any time and authorise the prior mentioned organisations to disclose all such information to Ulink Assist. A Photocopy of this authorisation shall be considered as effective and valid as the original.

I declare that the statements and answers stated are true and complete to the best of my knowledge and belief.

I consent to Ulink Assist (and its related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s) and/or managing my/our relationship with Ulink Assist
.
I also consent to Ulink Assist (and its related group of companies) transferring my/our personal data out of Myanmar to Ulink Assist related group of companies and/or third party service providers, reinsurers, suppliers or intermediaries whether located in Myanmar or elsewhere, for the above purposes..

☐ I declare that my submitted documents are originals and not claiming from third parties.

_____ Signature of Policyholder

_____ Signature of Patient

_____ Date (DD/MM/YY)

MEDICAL INSURANCE CLAIM FORM

SECTION B: TO BE COMPLETED BY ATTENDING PYSICIAN/SURGEON
(For Outpatient claims, please complete item 1 to 14 only)
(The Medical Report Fee, if any will be borne by the Claimant)

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PATIENT INFORMATION	
Policy No.	Name of Company:
Name of Patient:	NRIC/Passport No:
Date of Appointment: Admission date: Discharge date:	

Nature of Illness	Nature of Treatment/Surgery
01) Final Diagnosis of illness or extend of injury (ICD Code if any): Date of Diagnosis:	04) Date of surgical procedure or treatment rendered (Operation code if any):
02) Given the aetiology of the condition, please state the estimated date that such condition would be in existence.	05) Details of surgery/treatment/medication given:
03) Cause of illness/injury?	06) If excision was performed, please indicate the size of the lesion/tumour. (Please attach a copy of the Histology Report)
07) Name of a) Physician: b) Surgeon: c) Anaesthetist:	

08) Is the condition related to:	Yes	If "Yes", please elaborate.	No
a) Pregnancy or Childbirth	☐		☐
b) Abortion or Miscarriage	☐		☐
c) Infertility or Sub-fertility Condition	☐		☐
d) Congenital Anomaly	☐		☐
e) Genetic or Chromosomal Disorder	☐		☐
f) Mental or Psychiatric Condition	☐		☐
g) Cosmetic Surgery	☐		☐
h) Is the surgery for correction of short sightedness?	☐		☐
i) Is the surgery for dental purposes	☐		☐

Medical History	
09) Name and address of referring doctor (if any):	14) If there are no symptoms presented, what prompted the patient to see you?
10) When did the patient first consult you for this condition?	15) Please specify the approximate date of discovery of the illness or injury
11) Nature and Date of Treatment rendered	16) How long has the illness/injury existed prior to consulting you?
12) What were the symptoms/complaints prior to consulting you?	17) Has the patient ever had the same or similar condition/symptom? ☐ Yes ☐ No ☐ Not to my knowledge
13) Please indicate the nature of Symptoms and date Symptoms first started	18) Doctors previously consulted by the patient for the above condition. Name of Doctors: First Consultation: Name of clinic:
19) Is the patient still under your care for this condition? ☐ Yes ☐ No If Yes, please state the estimated duration that patient needs to follow up with you.	If No, please give termination date of service and furnish name and address of doctor if the patient has been referred to another doctor for follow up

_____
Signature of Physician/Surgeon

_____
Date

_____
Name/Designation

_____
Name and Address of Clinic/Hospital & Stamp

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ANNEX 1: PLEASE COMPLETE BELOW SECTION FOR BANK ACCOUNTS OUTSIDE OF MYANMAR

BENEFICIARY BANK DETAILS	
Name of Beneficiary	Name of the Beneficiary Bank
Beneficiary address	Address of the Beneficiary Bank
Beneficiary Bank Account Number	Country of the Beneficiary Bank
SWIFT Code	Clearing Code

INTERMEDIARY BANK DETAILS	
Bank Name	Address
SWIFT Code	Clearing Code