

PRE-ADMISSION FORM FOR LOG

Please furnish the following information/documents to Ulink Assist Myanmar:

- i. Please fully complete all sections in order for us to process pre-admission letter of guarantee
- ii. Relevant medical documents
- iii. Estimated length of stay and estimated cost from hospital
- iv. Please submit a new form for each separate visit, illness or injury
- v. Incomplete information and medical documents may result in rejection or delay of LOG process

B. PART (1) - TO BE COMPLETED BY INSURED OR POLICY OWNER

Section A: Patient Information

Name of Patient	
Policy Number	
NRC	
Date of Birth	
Admission date	
Hospital Name	
Doctor Name	
Room type/ Ward type	

Section B: Contact details

Email	
Contact Number	

Section C: Declaration, Consent and Authorisation by insured or policy owner

By completing the form, I hereby declare that:

- (a) I am the patient, or the patient's parent or guardian if the patient is under 18 years of age.
- (b) All information on this pre-admission form is true and correct based on the best of my knowledge.
- (c) I authorize my treating doctor(s), clinic, hospital or any other medical provider to provide access and furnish all necessary and relevant reports and/or medical and invoice information pertaining to my personal data and medical condition (these may include information regarding past medical history,

psychological notes, drug or alcohol abuse notes, AIDS and other sexually transmitted disease related information) to Ulink Assist Myanmar, including its associate companies, partners and affiliates, as may be required.

- (d) I further authorise Ulink Assist Myanmar, including its associate companies, partners and affiliates to have access, to use, to receive and to share for valid purpose such reports and/or information obtained from myself, authorised representatives, treating doctor(s), clinic, hospital or any other medical provider for the purpose of evaluating and providing my medical care, assistance services or healthcare benefits administration services, as well as to coordinate, assess and determine my entitlements, benefits and/or reimbursements in connection with my health or medical insurance coverage.
- (e) I acknowledge that the information submitted herein shall be used only for the pre-authorisation of direct settlement by Ulink Assist Myanmar with the clinics/hospitals for any eligible and approved charges relating to my approved medical treatment. I agree to pay any excess amounts and uncovered medical expenses (if any) to clinics/hospitals or Ulink Assist Myanmar within 7 business days from date of request. The actual covered amount is subject approved based on the information provided in the pre-admission form, actual diagnosis, eligible policy benefit, exclusion clause, terms and conditions stated in the policy document.

Signature		Date of consent	
Insured name		Relationship to patient (If applicable)*	

*If this authorisation is being signed by a personal representative on behalf of the patient

C. PART (2) - TO BE COMPLETED BY ATTENDING DOCTOR

Section A: Medical details

- a) Diagnosis / Provisional Diagnosis
- b) Is the condition and treatment related to the following:
- ☐ Pregnancy / Childbirth / Infertility / Miscarriage Or any complications arising therefrom
 - ☐ Congenital / Hereditary disease
 - ☐ Drugs / Alcohol abuse
 - ☐ Mental / Psychiatric disorder
 - ☐ Cosmetic reason / Dental care / Refractive errors correction
 - ☐ STD / AIDS/ HIV related
 - ☐ None of the above

c) Details of clinical features

Date of first consultation
Estimated date of onset of symptoms
Duration of symptoms
Description of signs and symptoms

d) Can the condition be managed under Outpatient basis?

☐ YES ☐ NO

If YES, please provide reason for this hospitalisation

e) Any previous consultation / treatment / hospitalization for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities prior to current admission?

☐ YES ☐ NO

If YES, please send previous hospitalisation and medical reports.

f) Name of surgery or procedure (if applicable)

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g) Estimated length of stay in hospital

h) Estimated hospital cost

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- i) If hospitalization was due to injury, please indicate date and time of injured event and describe circumstances and cause of injury

Date and time of accident:

Circumstances and cause of injury

- j) Additional attachment if any (E.g., Relevant Medical Record, Referral Letter, Police report for accident, biopsy report)

Section B: Declaration, Consent and Authorisation by attending doctor

By completing the form, I hereby declare that:

- (a) I have personally examined and treated the Insured (i.e. patient) in respect of the medical condition described above and that the information stated above represent my genuine and honest opinion of his/her condition and my recommended treatment; and
- (b) All information on this pre-admission form is true and correct based on the best of my knowledge.
- (c) I authorize (name of insurer) to release this medical information (these may include information regarding past medical history, psychological notes, drug or alcohol abuse notes, AIDS and other sexually transmitted disease related information) to Ulink Assist Myanmar, including its associate companies, partners and affiliates, as may be required.

Doctor's Name		Doctor's Signature	
Medical License No. (or) Stamp of Doctor		Date of declaration	

Health Claim Management Information

- Dai-ichi Life committed to ensuring the highest standards of customer care and satisfaction. As part of our dedication to delivering reliable health claim services, we have partnered with Ulink Assist Myanmar, a trusted and reputable organization specializing in health claim management.
- Please contact **+95 9 774 777 733** for customer service or general information.



16-09, Office Tower 2, Times City, Hanthawaddy Road, Kamayut Township, 11041, Yangon.