

### Personal Accident Claim Form

Suggestion: To be completed this claim form and returned to our head office with other documents

Details of claimant :  Insured  Beneficiary  Legitimate heir  other.....

Name-Surname..... Policy Number.....

Passport no./ID card no.....Nationality.....Date of birth.....

Address for connection.....

Telephone or Mobile phone.....

Occupation and job description.....

E-mail Address.....

Details of loss : Accident Date...../...../..... Time : at..... AM / PM

Place of accident : .....

Cause of accident : .....

Symptoms of injury and nature of wound : .....

Underlying Disease :  No  Yes please give the name of disease.....The disease happened for.....Years

Details amount Medical Service

OPD  IPD : Admission date...../...../.....To Discharge date...../...../..... Total.....Days

Medical expenses cost..... Bath Hospital name.....

Other insurance / other coverage  Social security  Compulsory Motor Insurance  Other.....

Name of Insurance Company / other coverage.....Policy number.....

In case of accident caused by Third party  Known Doer  Unknown Doer

Is this accident reported to the police ?  No  Yes (Please attach the police report)

In case of accident caused by vehicle / Injured person is :  Driver  Rider  Passenger  Side walker

Type of vehicle  Sedan Car  Truck  Bus  Motorcycle  Motor tricycle  Other.....

Brand.....Vehicle Numeration.....Province..... Dose the vehicle has insurance?  No  Yes

Name of Insurance Company.....Policy Number.....You are  Wrong  Right  Wait for lawsuit

I warrant that above details are correct. I hereby authorize Thanachart Insurance to seek any medical information / other details from doctors/Specialists or other sources and I also give my consent to the related parties to submit any information needed.

I agree that a photocopy of this authorization shall be as the original.

Signature.....Insured/Claim person

(.....) Date...../...../..... (To submit document)