

## CLAIM FORM FOR INDIVIDUAL CUSTOMERS

**By signing and submitting this Claim Request Form, the claimant acknowledges that they fully understand and accept legal responsibility for the accuracy of the information provided. Failure to disclose or provide truthful information may result in the rejection of the compensation claim or a longer processing time than committed in the insurance contract.**

### I. INFORMATION ABOUT THE INSURED PERSON

Insurance Card Number/Certificate of Insurance number/ Contract of Insurance number: CAPITAL LETTERS, including periods (.)

\_\_\_\_\_

Effective from:  /  /

Valid until:  /  /

Name of the Insured: \_\_\_\_\_

ID/Passport Number: \_\_\_\_\_

Date of Birth:  /  /

Workplace: \_\_\_\_\_

Contact Address: \_\_\_\_\_

Is there any other insurance coverage for the same event being claimed?

No, only one insurance policy as above  There is another insurance policy with the Insurance Company: \_\_\_\_\_

### II. INFORMATION ABOUT THE INSURANCE EVENT

Date of incident:  /  /

Treatment type:  Out-patient  In-patient  No treatment

Treatment at: \_\_\_\_\_

Date of admission:  /  /

Doctor's Diagnosis/Accident Cause: \_\_\_\_\_

**TOTAL AMOUNT OF CLAIM REQUEST:**  (VND)

### III. INFORMATION ABOUT THE CLAIMANT (Skip this section if the Claimant is the Insured Person)

Note: The Claimant can only be the Insured person or the following individuals:

- a) Beneficiary/designee in the Insurance Contract/Certificate or in the Inheritance Division Document;
- b) Authorized person: must provide a notarized Power of Attorney or be confirmed by the People's Committee at ward/commune level or equivalent documents;
- c) Father/mother/legal guardian of the Insured Person under 18 years old: must provide Household Registration Book or Birth Certificate, documents proving the guardianship, or other documents as required by law.

Name of the Claimant: \_\_\_\_\_ ID/Passport Number: \_\_\_\_\_

Date of Birth:  /  /

Contact Address: \_\_\_\_\_

Relationship with the Insured Person:  Parents  Child  Spouse  Other, please specify: \_\_\_\_\_

### IV. INFORMATION ABOUT THE METHOD OF RECEIVING COMPENSATION (Please tick the appropriate box)

Cash at Bao Viet Insurance  
Note: Please present personal documents (ID card, Passport...) when receive cash.

Bank Transfer  
Account No: \_\_\_\_\_  
Name of Beneficiary: \_\_\_\_\_  
Bank: \_\_\_\_\_ Branch: \_\_\_\_\_

### V. INFORMATION OF RECEIVING CLAIM PROCESS UPDATES FROM BAO VIET INSURANCE

Phone number: \_\_\_\_\_

Email: \_\_\_\_\_

#### COMMITMENT:

1. By submitting the complete claim dossier, including this Claim Form, the Insured person and all parties involved solemnly pledge to comply with the applicable insurance laws and regulations regarding insurance concurrence and agree to abide by the General Terms and Conditions of Bao Viet Insurance regarding Privacy and Data Processing, as stipulated at the following link: <https://www.baoviet.com.vn/insurance>. Furthermore, they grant permission to Bao Viet Insurance and/or their representatives to:

- Access third parties in order to collect necessary information for the claim assessment, including but not limited to contacting the attending physicians of the Insured Person.
- Collect, process, and store personal data within the claim dossier to fulfill the obligations under the Insurance Contract/Certificate and other related tasks as prescribed by law.

2. In case the insurance payment amount is found to be inaccurate concerning the benefits specified in the contract, all parties are entitled and obliged to make supplementary payments or refund the inaccurate payment amount to the remaining parties.

Date ..... / ..... / 20.....

**CLAIMANT**

(Signature and full name of the claimant)

#### LIST OF DOCUMENTS:

- |  |  |
|--|--|
| <input type="checkbox"/> Hospital Admission/Discharge form: _____ sheets | <input type="checkbox"/> Invoice, receipt: _____ sheets  |
| <input type="checkbox"/> Medical Prescription: _____ sheets              | <input type="checkbox"/> Accident report: _____ sheets   |
| <input type="checkbox"/> Test laboratory, X-ray results: _____ sheets    | <input type="checkbox"/> Death Certificate: _____ sheets |
| <input type="checkbox"/> Surgical consent form _____ sheets              | <input type="checkbox"/> Other documents: _____ sheets   |

