FORM CLAIM – INDIVIDUAL INSURANCE

(To be filled by Policy Holder/Insured/Beneficiary older than 17 years old or by the Legal Guardian)

☐ DEATH
☐ TOTAL PERMANENT DISABILITY
☐ ACCIDENTAL DEATH & DISMEMBERMENT
☐ OUTPATIENT
☐ INPATIENT
☐ CRITICAL ILLNESS
☐ WAIVER OF PREMIUM
(CRITICAL ILLNESS, DISABILITY & DEATH)

Please complete all the questions below to expedite the claim process

Policy Holder/Insured

Policy Holder Name : _____ M/F
Insured Name : _____ M/F
Date of Birth of Insured : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)
Policy Number : _____

Only for Death Claim

Beneficiary Name : _____ M/F
Relationship : ☐ Spouse ☐ Parent/Child ☐ Sibling ☐ Other: _____

Correspondence Data Changes

Policiy Holder Home/Cell Phone No. : _____ Beneficiary Home/Cell Phone No. : _____
Home Address : _____
Email Address : _____

**I understand by filling this correspondence data changes, PT Asuransi Jiwa Generali Indonesia will update my correspondence data based on information in this form.*

Cause of Treatment or Death — ☐ Disease ☐ Accident ☐ Other: _____
Symptoms & cause of Hospitalization or Death — _____
When did the symptoms first occur to the Insured prior to the first consultation? — ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY), or since : _____
Is the cause of Hospitalization/Death related to alcohol/drugs/other subtances? — ☐ No ☐ Yes, please explain: _____
Has the Insured been hospitalized/treated for the same disease or other diseases before? — ☐ No ☐ Yes ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)
If yes, please complete the date of treatment & doctor's name, address, and/or hospital — Doctor's Name and Address/Hospital: _____

If Related to Accident

Location & Date of Accident — ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)
Chronology of the Accident — _____

Other Insurance Policy

Insurance Company : _____
Insurance Product : _____ Policy No. : _____
Policy Effective Date : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Please issue the Coordination of Benefit letter if there is an excess that is not covered by PT Asuransi Jiwa Generali Indonesia
☐ Yes ☐ No

Claim Payment will be transferred to: *(Life Benefits will be paid to Policy Holder & Death Benefits will be paid to the Beneficiary)*

Account Holder: _____ Account No. : _____ Name of Bank : _____
Branch : _____ Note: _____

POWER OF ATTORNEY & DECLARATION

The Undersigned

Principal Name : _____
Address : _____
Date of Birth : _____/_____/_____ (DD/MM/YYYY)
ID Number : _____
Relation with Insured : ☐ Self ☐ Husband/ Wife ☐ Parent/Child ☐ Siblings ☐ Other: _____

Insured Name : _____
Address : _____
Date of Birth : _____/_____/_____ (DD/MM/YYYY)
ID Number : _____

Hereby I declare that I have read, understand, answered all the questions above completely and correctly, and give the authority to the doctors, clinics, hospitals, society health centers, laboratories, all medical institutions, insurance companies, law firms, institutions or individuals who have the medical record/information of the insured, to share the information to PT Asuransi Jiwa Generali Indonesia or the people who are given the authority by insured, with all the medical record and all information that is related to the insured. A copy of this declaration is equally legally enforceable as the original copy.

Date _____/_____/_____

(Signature & Name)
Policy Holder/Beneficiary

(Signature & Name)
Insured

ATTENDING PHYSICIAN STATEMENT – INDIVIDUAL CLAIM FOR LIFE BENEFIT

(To be filled by the attending physician)

To : The Attending Physician

Dear Sir/Madam,
Kindly need your assistance to fill all the questions below completely and correctly to the extent of knowledge of the patient.

INFORMATION OF INSURED

Patient's Name : _____M/F Patient's Medical Record No. : _____

Date of Birth : _____/ _____/ _____ (DD/MM/YYYY), Age: _____ y.o. Patient's Address : _____

Type of Treatment: ☐ Inpatient ☐ Pre-/Post-Hospitalization ☐ Accident ≥/ ≤ 48 hours before Hospitalization
☐ Critical Illness ☐ One Day Surgery ☐ Total Permanent Disability

INFORMATION OF TREATMENT

Date of Treatment	From ☐ , ☐ , ☐ To ☐ , ☐ , ☐ (DD/MM/YYYY)
Anamnesis	
Diagnosis	
Cause of Treatment	☐ Accident ☐ Disease, please explain: _____

Please explain the indication for Hospitalization : _____

Was the Hosptialization requested by the patient? ☐ Yes ☐ No

Could the treatment be performed by without Hospitalization? ☐ Yes ☐ No

Date of The first diagnosis been estabilshed ☐ , ☐ , ☐ (DD/MM/YYYY)

When did the symptoms first occur to the Insured prior to the first consultation? ☐ , ☐ , ☐ (DD/MM/YYYY), or since: _____

The physician who referred the patient : _____ Hospital :_____

Medical Examination Result *(Laboratory, Radiology, MRI, CT scan, Angiography, Pathology Anatomy, USG, etc.)*	

Was a Surgery performed? : ☐ No ☐ Yes, please state the type of Surgery: _____

Purpose of Surgery : ☐ Curative ☐ Diagnostic

Was the diagnosis related to : ☐ Congenital ☐ Pregnancy, Delivery, or Abortion ☐ Psychiatric/Mental Disorder
☐ Cosmetic ☐ Medical Checkup ☐ Transmitted Sexual Disease
☐ HIV ☐ Alcohol/Drugs Abuse

RELATED TO THE ACCIDENT/DISABILITY

Is there any part of the patient's body that suffer a disability?

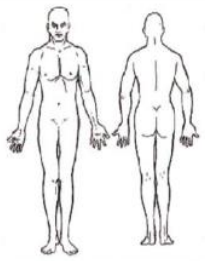
☐ No ☐ Yes, please explain the part of body that has disability: _____

What is the the type of disability?

☐ Permanent ☐ Temporary

Could the patient perform his/her job or vocation after suffering from the disability?

☐ No ☐ Yes, the patient might be able to start his/her job or vocation on/after how long: _____



MEDICAL HISTORY

Does the Patient have a medical history that is related to the following diseases:
Hypertension, DM, Heart Disease, Lungs, Psychological, Congenital, Drugs Abuse, HIV, etc.? ☐ No ☐ Yes, please explain: _____

Diagnosis : _____ Since : ☐ , ☐ , ☐ (DD/MM/YYYY)

The attending physician : _____ Hospital :_____

I hereby declare that I have read and answered all the questions above completely and correctly to the extent of my knowledge.

Doctor's Name : _____Specialization: _____

Doctor's Address/Hospital : _____

Home/Cell Phone No. : _____

Date _____/_____/_____ (DD/MM/YYYY)

_____
(Doctor's Signature & Hospital Stamp)