GENERALI

CLAIM FORM

(FOR GROUP INSURANCE)

Card Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Claim No: ☐☐☐☐☐☐☐☐

Policy Holder (Company Name): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

I. PERSONAL INFORMATION

CLAIMANT

Is ☐ Policy Holder ☐ Dependant
☐ Insured Member ☐ Beneficiary ☐ Other relationship: .....

Fullname (in CAPITAL): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D.O.B: ☐☐/☐☐/☐☐☐☐ Telephone: ☐☐☐☐☐☐☐☐☐☐

ID card/Passport number: ☐☐☐☐☐☐☐☐☐☐☐☐ Issued date:.../...../..... Issued place: .....

Email: .....

INSURED MEMBER (of the insurance benefit settled under this request)

Fullname (in CAPITAL): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D.O.B: ☐☐/☐☐/☐☐☐☐

ID card/Passport number: ☐☐☐☐☐☐☐☐☐☐☐☐ Issued date:../...../..... Issued place: .....

Telephone: ..... Email: .....

Address: ..... City:.....

II. CLAIM INFORMATION

1. Insurance Benefit:

☐ Inpatient ☐ Outpatient ☐ Dental ☐ Maternity ☐ General Heath check ☐ Income compensation

Information for examination and treatment *(Please submit document related to each benefit)*

Treatment Place	Consult/Admission Date	Discharge Date	Diagnosis
……..	☐☐/☐☐/☐☐☐☐	☐☐/☐☐/☐☐☐☐	.....
……..	☐☐/☐☐/☐☐☐☐	☐☐/☐☐/☐☐☐☐	.....
……..	☐☐/☐☐/☐☐☐☐	☐☐/☐☐/☐☐☐☐	.....

Claim amount: ……..VND

2. Other benefit:

☐ ADD ☐ Term Life

Event Date: ☐☐/☐☐/☐☐☐☐

Reason: ☐ Illness *(Please submit related medical document)* ☐ Accident *(Please submit document related to accident)*

Diagnosis: .....

Address: Claim Department - Generali Plaza, No 43-45 Tu Xuong, Vo Thi Sau Ward, District 3, Ho Chi Minh City

III. PAYMENT INFORMATION

☐ **Bank Transfer**

Account Name:
(in CAPITAL)

Account Number:

Bank Name: ☐ Commercial (Vietcombank) ☐ Industrial (Vietinbank)
☐ Investment & Development (BIDV) ☐ Other (with clear name) .....

Branch:..... Transaction office: ..... City:.....

Attached Document (*please tick (x) on the square for document you submit*)

☐ Discharge Certificate ☐ Invoice ☐ Death Certificate
☐ Surgery Certificate ☐ Receipt ☐ Accidental Report
☐ Prescription/Medical Book ☐ Breakdown of Charge ☐ Leave request
☐ Laboratory test/Special Imaging result ☐ Request for Laboratory test/Special Imaging
☐ Other document: ....……

……

IV. COMMITMENT REGARDING TO THE FOREIGN ACCOUNT TAX COMPLIANCE ACT (FATCA)

Please check the appropriate box below (if any):

I am/We are citizen(s) or long-term resident(s) of the United States (U.S.) ☐

I/We have some aspects related to U.S. including: having U.S. birth certificate/U.S. home address/ U.S. telephone number. ☐

I/ We have U.S. tax filing obligations ☐

In case the claimant is citizen/organization of U.S. or has some aspects related to U.S. and has U.S. tax filing obligations in accordance with the foreign account tax compliance act (FATCA), please submit W9/W8 form as per Generali staff's instruction.

V. COMMITMENT AND ARGEEMENT

I/We:

(a) Hereby certify that all the information provided on this form along with the documents enclosed are complete and accurate to the best of my/ our knowledge and ready to provide other documents for claim processing if required.

(b) Give permission and authorize any organization, company or individual who has knowledge of the occupation, health, medical history, insured event of insured person to provide Generali or Generali 's representative any information required,

(c) Give Generali permission to use my/our address, telephone number, email in order to provide information required to complete the assessment of this claim.

(d) In case violating the insurance policy, I/we ensure to refund the excess amount or the amount is not covered by the insurance policy which Generali already paid

CLAIMANT *(Signature and full name)*	**COMPANY'S CONFIRMATION** *(Signature and stamp)*
Full name: …… Date:……../……../……..	Full name: …… Date: ……../……../……. *(Applied for death claim)*