



Document Checklist for Serious Disease Claim (GCIR)

Name of insured Policy no.....
 Company..... Insurance certification no.
 Submitted by..... Date.....Telephone.....

	Submitted	Not submitted
<u>In case of serious disease claim (from illness)</u>		
1. Serious Disease Claim Application Form	<input type="checkbox"/>	<input type="checkbox"/>
2. Physician's report in case of serious disease	<input type="checkbox"/>	<input type="checkbox"/>
3. A copy of medical history from the onset of illness to date (OPD card) from all hospitals receiving treatment	<input type="checkbox"/>	<input type="checkbox"/>
4. A copy of biopsy result indicating serious disease diagnosis (pathology)	<input type="checkbox"/>	<input type="checkbox"/>
5. A copy of special examination results e.g. X-ray film, CT, MRI	<input type="checkbox"/>	<input type="checkbox"/>
6. A certified copy of the insured's ID card	<input type="checkbox"/>	<input type="checkbox"/>
7. A copy of the job application and employment contract certified true copy by the Human Resources Department	<input type="checkbox"/>	<input type="checkbox"/>
 <u>In case of serious disease claim (from death)</u>		
Note: Submit the serious disease claim documents item no.1-5 together with the documents listed in the Document Checklist for Death Claim		
<u>Other important documents to be submitted depending on the case</u>		
● A certified copy of the evidence of the insured's or the beneficiary's name/surname change if it does not match with that on the policy.	<input type="checkbox"/>	<input type="checkbox"/>

This section is for Company officer only

The Company has received and examined the above documents. It appears that the documents are

Complete

Incomplete. The missing documents are.....

Group Insurance Claim Division Date

Critical Illness Claim Application Form (GCIR)



Please complete the form only by the insured/claimant having an interest in the insured and sign.

Warning: Any fraudulent claim or false evidence or any activity supported to the fraud would be imprisoned for maximum 3 years or fine for 300,000 Baht or both according to Section 114/4 of the Life Insurance Act 2019.

Name of insured	Age	ID card no./Passport no.	Policy no.
Address and telephone			This claim is <input type="checkbox"/> First claim <input type="checkbox"/> Ongoing claim no.
Workplace.....		Position.....	
Job description/responsibilities.....			
Did you submit a leave letter to your employer or supervisor? <input type="checkbox"/> Not submitted <input type="checkbox"/> Submitted starting from.....to.....			

Claim details (Please specify briefly.)

1. Claim for what illness?.....

2. Symptoms of the illness.....

3. How long have you had these symptoms before consulting a doctor?.....

4. Date of first consultation.....

Details of treatment from physicians

Name of physician	Hospital/Clinic	Treatment date	Treatment
.....
.....

You have the right to claim No Compensation fund Social security Other rights, if any (specify).....

Did you receive compensation? Not yet Received Date

Personal Data Protection Statement and Consent Request:

I and/or my legal representative acknowledge that the Company will process my and/or the minor's personal data in order to provide claim and life insurance services in accordance with the details set out in the Privacy Policy announced by the Company on <https://www.tokiomarine.com/th/en-life/global/privacy-policy.html> or the QR code below. I hereby certify and guarantee that the personal data of any other person that I disclose to the Company for the purposes stated in this form is correct and complete. In addition, I have obtained the consent from the data subject for the Company to process the data and informed the Company Privacy Policy to such person.



I and/or legal representative

1. Give consent to physicians, medical facilities, other insurance companies or related persons who possess my and/or the minor's past or future personal data e.g. health, disability, sexual behavior, biological, genetic and ethnic information; medical history; or any other information necessary for the consideration of claim payment to disclose such data to the Company or Company insurance agents or Company representatives or insurance brokerage companies or policyholders or other insurance companies for insurance application or payment under the insurance policy or any action related to the insurance policy or for fraud risk management.
2. Give consent to the Company to collect, use, and disclose my and/or the minor's personal data e.g. health, disability, sexual behavior, biological, genetic and ethnic information; medical history; or any other necessary information to legal authorities or reinsurance brokerage companies or reinsurance companies; related persons; Company insurance agents, personnel or representative; or policyholders and/or insurance brokerage companies for insurance application or payment under the insurance policy or for medical use or any action related to the insurance policy.

I understand that if I do not consent or withdraw my consent under item 1 and/or 2, it will affect the underwriting, policy payment, or any services related to the insurance policy, which will result in the Company being unable to comply with the conditions in the insurance policy and I will not be provided the coverage according to the insurance policy. In addition, I acknowledge that my consent will remain effective until I withdraw it or to the extent permitted by law, which if contrary to or inconsistent with the law I agree to proceed in accordance with the law or with the new procedure which will be notified by the Company

Insured/Consenter: Giving consent as

(.....) Father/Mother

Date..... Legal representative/Insured's legal guardian (In the event that the insured is not of legal age)

Human Resources Department/Employer's Certification

I, as Human Resources Department/employer who has made this claim, hereby certify that this claim and any answers to the questions in this document are true to the facts I have received.

Sign

(.....)

Human Resources Department/ Employer

Date.....