Medical Certificate Form

Patient's Name/Surname………………………………………… HN…………… AN……………

Age……………years Sex ☐ Male ☐ Female ID No……………………………

Admission Date……………………Time…………… Discharge Date……………………Time……………

For Illness:

1. Date you first saw this patient for this illness: ……………………………………
2. Chief complaint and duration of symptoms: ……………………………………
3. In your opinion, how long should this symptoms persist for this illness: ……………………

For Accident :

1. Date &time of accident……………………… Date & time you first saw this patient………………
2. Cause of accident, nature of wound, injured organs: ……………………………………
3. Was the patient under the influence of alcohol or drugs at the time of arrival to the hospital?

☐ No ☐ Yes, please give details ……………………… Blood alcohol test = ……………mg%

Patient Clinical findings (Symptoms & Signs): ……………………………………

……………………………………………………………………

Underlying diseases : ……………………………………………

Did the patient need to be admitted to hospital? ☐ No ☐ Yes, please give the indication……………………

Expected Length of stay……………………day(s) For accident: Estimated time for recovery……………………

Investigation & Result: ……………………………………………

……………………………………………………………………

……………………………………………………………………

HIV test ☐ Not done ☐ Done Result……………………… Date performed………………

Are the investigations relevant to the diagnosis? ☐ No ☐ Yes

Final Diagnosis 1: …………………………………… ICD-10 code……………

Diagnosis 2: …………………………………… ICD-10 code……………

Diagnosis 3: …………………………………… ICD-10 code……………

Treatments given (such as number of stitches, medical given, physiotherapy,etc): ……………………

……………………………………………………………………

……………………………………………………………………

Surgery /Operation: …………………………………………… ICD -9CM or 10M……………

Date of operation…………… Result / Complications: ……………………………………

Pathology result……………………………………………………

Is the illness related to alcohol, drug, abuse or addiction? ☐ No ☐ Yes, please give details ……………

For female: Is the patient pregnant? ☐ No ☐ Yes Gestational age ……………Weeks

Was the treatment related to pregnancy or treatment of infertility? ☐ No ☐ Yes……………………

Has the patient been treated by other doctor? ☐ No ☐ Yes, please give name and address ……………

To the best of your knowledge, please give details of all previous consultations for serious disorders for this patient.

Date	Diagnosis	Treatment	Duration	Physician / Hospital Name

Other comments: ……………………………………………………

……………………………………………………………………

I hereby certify that I have personally examined and treated the insured in connection to the above disability and that the facts are in my opinion as given above.

Signature …………………………………… License number: ……………………………

( ) Specialty: ……………………………

Date……………………………

Disability/Dismemberment Claim Application Form

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 ☐ First claim ☐ Ongoing claim no. ....

Workplace.. Position..

Job description/responsibilities...

Did you submit a leave letter to your employer or supervisor? ☐ Not submitted ☐ Submitted starting from....................................to……..............................

Details of disability/dismemberment (Please specify briefly.)

Date of onset of dismemberment...

Cause of dismemberment ☐ Accident ☐ Illness

....

Part of the body where the organ was lost (Please specify the organ.) ....

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: ……..................……………………………………

(..)

Date..

Giving consent as

☐ Father/Mother

☐ 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...

Ophthalmologist Form

ชื่อผู้ป่วย (Claimant's Name).. อายุ (Age)......................... ปี (Years)

ที่อยู่ (Address)..

....

วันที่ตรวจ (Eye Examination Date)..............................โรงพยาบาล/ คลินิก (Name of Hospital)..

ประวัติการบาดเจ็บ/เจ็บป่วยที่ตา (History of Eye Injury/ Illness)..

....

....

....

ผลของการตรวจตา (Eye Examination)	ตาขวา (Right Eye)	ตาซ้าย (Left Eye)
- ระดับสายตา (Visual Acuity)	....	....
- ส่วนหน้าของตา (Anterior Chamber)	....	....
- ประสาทตา (Optic Nerve)	....	....
- ความดันตา (Eye Pressure)	....	....

การวินิจฉัย (Diagnosis)...

การรักษา (Treatments)...

....

....

การพยากรณ์โรค (Prognosis)...

....

การสูญเสียการมองเห็น (Visual Blindness)	☐ ตาขวา (Right Eye)	☐ ถาวร (Permanent)	☐ ชั่วคราว (Temporary)
	☐ ตาซ้าย (Left Eye)	☐ ถาวร (Permanent)	☐ ชั่วคราว (Temporary)

สาเหตุการสูญเสีย (Cause of Visual Blindness)...

....

....

....

ความเห็นเพิ่มเติม (Additional Comment)...

....

....

....

I hereby certify that I have personally examined and treated the insured in connection to the above disability and that the facts are in my opinion as given above.

Name of Ophthalmologist: .... Signature:...…………………..

License No.: .... Specialty:...

Name of Hospital/ Official Stamp: .... Tel.: .... Date:...

Document Checklist for

Total Permanent Disability/Loss of Organ Claim

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

Documents for disability claim	**Submitted**	**Not submitted**
1. Disability/Loss of Organ Claim Application Form	☐	☐
2. Report by the attending physician in case of total permanent disability	☐	☐
3. A copy of medical history from the onset of disability to present (OPD card)	☐	☐
Additional documents to be submitted for the following cases		
1) In case of total permanent disability		
◙ Physical examination report of the insured by a regenerative medicine doctor	☐	☐
◙ Current photo (full body)	☐	☐
2) In case of loss of eyesight		
◙ Ophthalmologist report	☐	☐
◙ Current photo (front facing)	☐	☐
3) In case of loss of organ		
◙ X-ray film or a copy of X-ray film result	☐	☐
◙ Current photo (full body where the subject organ is visible)	☐	☐
Other important documents to be submitted depending on the case		
1. A copy of the evidence of the insured's name/surname change, if it does not match with that on the policy, certified true copy by the insured.	☐	☐
2. A copy of the job application, record of attendance time from the onset of disability to present, and evidence of receiving or paying salary in the last attending month, certified true copy by the Human Resources Department.	☐	☐
3. A copy of compensation payment of compensation fund.	☐	☐

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 ....