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 (.)*

Effecive 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:

☐ Hospital Admission/Discharge form: ____ sheets
☐ Medical Prescription: ____ sheets
☐ Test laboratory, X-ray results: ____ sheets
☐ Surgical consent form ____ sheets
☐ Invoice, receipt: ____ sheets
☐ Accident report: ____ sheets
☐ Death Certificate: ____ sheets
☐ Other documents: ____ sheets

BAOVIET DIRECT CLAIM ONLINE