



NOTIFICATION OF CLAIMS

(All sections must be completed)

SECTION A : PARTICULARS OF THE CLAIMANT

Patient's Name	
Insurance Policy Number	
Insurance Policy Holder	

SECTION B : AUTHORIZATION

I hereby authorize any hospital or physician or third party who has attended me to furnish to LMG Insurance Co., Ltd. (or its representative) and permit LMG Insurance Co., Ltd. (or its representative) to review any and all information requested with respect to any illness or accident, medical history, consultations, prescriptions, or treatments, copies of all hospital or medical records and the records of any governmental agency with which a report of any such accident or illness is lodged. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

SIGNED (PATIENT; OR PARENT IF A MINOR)

DATE

SECTION C : STATEMENT BY THE CLAIMANT (BY PARENT WHEN CLAIMANT IS A MINOR)

1. If as a result of an Accident:

(a) When did the accident occur? _____

Give a brief description of the circumstances: _____

(b) Which part (s) of body injured? _____

2. If as a result of an illness:

When did the symptom first appear? _____

SECTION D : DECLARATION

I, the undersigned, hereby declare that the particulars stated on this form are true in every respect. I have supplied full information on all particulars relevant to this claim, and the amounts claimed herein are lawfully due to me under the terms, conditions and exceptions of the above numbered account.

SIGNATURE OF PERSON INSURED

SECTION E : ATTENDING PHYSICIAN'S REPORT

PART 1

(a) What was the diagnosis you have made to the conditions of the patient and when was it made?

(b) If confinement in a hospital was required, state diagnosis of condition in respect of which hospitalization was required?

(c)(i) When did the symptom first appear? _____

(ii) When did patient first consult you on this condition? _____

(iii) To the best of your knowledge, has the patient ever had similar conditions or symptoms relating thereto or hospitalized for the same disorders? If "YES", please give dates and details. _____

(iv) To your knowledge, had patient previously consulted any other doctors for these symptoms? If "YES", please give names and address of the doctors: _____



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PART 1 (continue)

(d) Was the symptom a secondary condition to some other illness (es)? If "YES", please give details.

(e) Was the condition caused by or in anyway associated with the conditions mentioned below:

- (i) the influence of drugs or alcohol intake? Yes No
- (ii) AIDS? Yes No
- (iii) infertility or sterilization? Yes No
- (iv) cosmetic or plastic surgery? Yes No
- (v) psychiatric and mental disorder? Yes No
- (vi) congenital deformities or anomalies? Yes No
- (vii) suicide, insanity or self-inflicted injury? Yes No

(f) Are any of the conditions treated due to (please tick):

- (i) accident Yes No
- (ii) sickness or injury due to patient's employment Yes No
- (iii) pregnancy Yes No

If "YES", state approximate date of commencement of pregnancy _____

PART 2

(a) What was the period of hospitalization? Admission date: _____ Discharge date: _____

(b) What type of treatment was given to the patient?

(c) For surgical or maternity claims:

- (i) Name and nature of surgical or obstetrical procedure (s): _____
- (ii) Date(s) of procedure (s): _____

(d) Discharge summary report and details of any further treatment and/or follow up treatment recommended:

PART 3

Is it possible to provide this treatment on an outpatient basis? If "YES", please give reasons of performing this treatment on an inpatient basis.

NAME AND ADDRESS OF
ATTENDING PHYSICIAN

LICENCE No.

SIGNATURE OF ATTENDING
PHYSICIAN WITH STAMP

DATE