

Date		

	disability of \Box insure	ed / $lacksquare$ premium paver Nam	ıe								
Present Address Name - surname of guardian/curator (if any)			ID Card No. Mobile Phone No. / E-mail.								
						a. Type of benefits re	eguested				
						<u> </u>		fit due to accident/illness on		Caused by	
☐ Waiver of prer		·		•							
b. Information of disa	ability										
1. Date showing fi	rst disability condition.			Caused by							
				Medical center giving treatment							
				3 3							
4. Medical center t	that you received treat	ment of such disability									
Name of	Medical center	From	То	Treat	tment Result						
c. Documents for cla	im request 🔲 Copie	es of all medical records from	n medical center		Others						
d. Is an insured perso	on/premium payer entil	tled to receive compensation	n from other companies? \square No	Yes, please specify							
	ion collection channels										
			only. \square Receive at the Head Of								
		e PCL, Branch	Via agent Na	me	Feam/Department						
☐ Direct mail to	the current address										
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Remark: 1. In case of signing by fingerprint, signatures of 2 witnesses must be completely provided.

- *2. In case of a minor (not over 10 years old), a father/mother/legal guardian is required to sign and specify the relationship.
- *3. In case of a minor (over 10 years old but less than 20 years old), a father/mother/legal guardian is required to sign together with the minor and specify the relationship

2-02-05-0459

Comments from Physician Certifying Disability

Name-surname of patient	H.N	A.N.
Date showing first disability condition	due to	
Other existing underlying diseases		
Period of illness, started since	Medical center giving treatment	
Ability to perform activities of daily living	D	
1.1 Taking a bath		Need assistance from others
1.2 Dressing	The temperature of the temperature parties	Need assistance from others
1.3 Feeding	Able to eat food by oneself	Need assistance from others
1.4 Continence	☐ Able to control their bowel and bladder function	how incontinence of such function
1.5 Mobility	■ Able to move from place to place	Need assistance from others
Level of consciousness	Good Confused Somnolent Unconscio	us GCS score E M V
8. Ability to see		
Good sight of both eyes		ne eye, which is side VAside
Loss of sight in both eyes	Right VA Left VA Others	
. Ability to use hand and arm		
Able to use two hands and two a	arms to perform activities of daily living	
_	arm to perform activities of daily living, please specify side	
	o arms to perform activities of daily living	
Others		
. Ability to stand and walk		
	lk without assistance from others	
Unable to maintain balance and i	unable to stand up or walk by oneself	
. Mentality/behavior 🗖 Like normal people	Abnormal, please specify	
7. Ability to perform occupation, both permanent and others		
Able to perform permanent occu	upation and other occupations	
Unable to perform permanent of	ccupation and other occupations	
Assessment result		
Assessment result		
Does the patient have a chance to be cured of the disability of		
· ·		
☐ No chance of being cured		
Type of disability $igspace$ Temporary total disability $igspace$ P	Permanent partial disability	
Current ability level is		
Level 1 Totally unable or with little ability to perform activity	ties of daily living and require very much assistance	
Level 2 Able to perform activities of daily living by oneself t	to a certain degree and require much assistance	
Level 3 Able to perform activities of daily living by oneself a	a lot but may still need someone to help guide or look after or tools to a	aid disabled person or modification of personal
belongings. However, the patient is not able to leav	ve the house, continue with study, occupation, or join social gathering by	oneself in spite of under an environment that
supports disabled person.		
.,	lf with a use of tools to aid disabled person or modification of persona	al belongings. The patient is able to leave the
	ocial gathering by oneself under an environment that supports disabled p	
	If with a use of tools to aid disabled person or modification of persona	
house, continue with study or occupation, or join so		5 5 passana la doce do cadre dile
	eby certify that the above statement is true in all aspects.	
_	Attendin	
Medical license No	Medical center	
Date	MonthYear	

(Affix with medical center seal)