เมืองไทยประกันชีวิต
MUANG THAI LIFE ASSURANCE

Date.....

Claim for Total and Permanent Disability Benefits According to the Insurance Contract No.....

A total and permanent disability of ❑ insured / ❑ premium payer Name .....
Present Address..... Mobile Phone No. / E-mail.....

Name - surname of guardian/curator (if any) ..... ID Card No. .....
Present Address..... Mobile Phone No. / E-mail.....

a. Type of benefits requested

❑ Total and Permanent Disability benefit due to accident/illness on .....Caused by .....

❑ Waiver of premium

b. Information of disability

1. Date showing first disability condition.....Caused by.....
Condition.....Medical center giving treatment.....
2. Date of last appointment with physician.....Condition.....
..... Medical center giving treatment.....
3. Total number of days away from work.....
4. Medical center that you received treatment of such disability

Name of Medical center	From	To	Treatment Result

c. Documents for claim request ❑ Copies of all medical records from medical center..... ❑ Others.....

d. Is an insured person/premium payer entitled to receive compensation from other companies? ❑ No ❑ Yes, please specify.....

e. Claim/Compensation collection channels

❑ Transfer to the bank account/Promptpay given to the Company only. ❑ Receive at the Head Office of Muang Thai Life Assurance Public Company Limited

❑ Receive at Muang Thai Life Assurance PCL, Branch ..... Via agent Name.....Team/Department.....

❑ Direct mail to the current address

Declaration and Authorization of Medical History Disclosure

With this letter, I hereby give consent to the attending physician(s) or hospital(s) or any medical center(s) that has or had provided me/an injured person/a sick person with medical treatment to disclose the medical treatment history or other details pertaining to the treatment and health check result to Muang Thai Life Assurance Public Company Limited, and I authorize Muang Thai Life Assurance Public Company Limited or agent of the Company to act as a legal authorized person to proceed and contact to receive the aforementioned medical history from attending physician(s) or hospital(s) or any medical center(s) that has or had provided me/an injured person/a sick person with medical treatment or health checkup as if they were my own actions in all respects. A photocopy or copy of this letter is regarded as equally effective and complete as the original.

Declaration of Personal Data Disclosure

❑ I give consent to the Company to collect and use Personal Data, health information, disability, religion, race, medical record, and claim record of me and/or the person under my guardianship (as the case may be), both provided above at present and in the future (collectively referred to as "Sensitive Data"). This consent also includes disclosure of such Sensitive Data as necessary to executives, employees and life insurance agents of the Company, life insurance brokers, banks, reinsurance companies, other insurance companies, medical centers, group insurance policyholders, the Thai Life Assurance Association (TLAA), units with duty to collect/pay policy benefits, government agencies, agencies and commissions which are responsible for law enforcement or legally registered, state agencies or regulators, the Company's business partners, foundations, and the Company's vendors or services providers, to allow the Company, persons and agencies to collect and use the Sensitive Data as necessary and required by law for the purposes of insurance application, underwriting, policy benefit payment, medical treatment, and as a central database of insurance companies in order to examine insured's history and claim record, any operations regarding insurance policies, future insurance application and for any purposes which benefit the insured.

I acknowledge that by not giving consent and by changing the scope of consent, withdrawing consent, objecting, requesting for erasure or destruction of Personal Information, it may result in the Company being unable to manage or take any necessary action on the insurance contract and may affect services and policy benefit payment. In this regard, I have already acknowledged the Company's Privacy Policy on www.muangthai.co.th/th/privacy-policy. In this regard, the expression of my intention by marking ✓ in ❑ constitutes that I have given explicit consent to collect, use and disclose the Personal Data according to the purposes specified above. Hereby, I have signed as evidence thereof.

I have explicitly acknowledged the statements above and the Company's Privacy Policy and hereby signed to authorize and give consent to the disclosure of medical history above.

Scan for details of Privacy Policy

Sign.....Personal data provider/Insured/Premium payer Sign.....Guardian/Curator

( ) ( )

Sign.....Witness Sign.....Witness

( ) ( )

If the beneficiary is a minor (less than 20 years old), a father/mother/legal guardian must additionally sign this section to give consent as stated above and specify relationship.

*Sign .....Consent Grantor Relationship with the minor.....

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

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.....

1. Ability to perform activities of daily living

1.1 Taking a bath	❑ Able to wash oneself	❑ Need assistance from others
1.2 Dressing	❑ Able to put on or take off tops and pants	❑ 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

2. Level of consciousness ❑ Good ❑ Confused ❑ Somnolent ❑ Unconscious ❑ GCS score E __ M __ V __

3. Ability to see

❑ Good sight of both eyes Right VA_____ Left VA_____ ❑ Loss of sight in one eye, which is side VA.....side

❑ Loss of sight in both eyes Right VA_____ Left VA_____ ❑ Others .....

4. Ability to use hand and arm

❑ Able to use two hands and two arms to perform activities of daily living

❑ Unable to use one hand and one arm to perform activities of daily living, please specify side.....

❑ Unable to use two hands and two arms to perform activities of daily living

❑ Others.....

5. Ability to stand and walk

❑ Able to maintain balance and walk without assistance from others

❑ Unable to maintain balance and unable to stand up or walk by oneself

6. Mentality/behavior ❑ Like normal people ❑ Abnormal, please specify.....

7. Ability to perform occupation, both permanent and others

❑ Able to perform permanent occupation and other occupations

❑ Unable to perform permanent occupation and other occupations

b. Assessment result

1. Does the patient have a chance to be cured of the disability or not ?

❑ Yes, because.....

❑ Not conclusive, because.....

❑ No chance of being cured

2. Type of disability ❑ Temporary total disability ❑ Permanent partial disability ❑ Total and permanent disability

3. Current ability level is.....

Level 1 Totally unable or with little ability to perform activities of daily living and require very much assistance

Level 2 Able to perform activities of daily living by oneself to a certain degree and require much assistance

Level 3 Able to perform activities of daily living by oneself a lot but may still need someone to help guide or look after or tools to aid disabled person or modification of personal belongings. However, the patient is not able to leave the house, continue with study, occupation, or join social gathering by oneself in spite of under an environment that supports disabled person.

Level 4 Able to perform activities of daily living by oneself with a use of tools to aid disabled person or modification of personal belongings. The patient is able to leave the house, continue with study or occupation, or join social gathering by oneself under an environment that supports disabled person.

Level 5 Able to perform activities of daily living by oneself with a use of tools to aid disabled person or modification of personal belongings. The patient is able to leave the house, continue with study or occupation, or join social gathering similarly to a normal person.

I hereby certify that the above statement is true in all aspects.

Sign.....Attending physician

Medical license No.....Medical center.....

Date.....Month.....Year.....

(Affix with medical center seal)