เมืองไทยประกันชีวิต
MUANG THAI LIFE ASSURANCE
บมจ. เมืองไทยประกันชีวิต
250 ถนนรัชดาภิเษก เขตห้วยขวาง กรุงเทพฯ 10310
Muang Thai Life Assurance PCL
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Group Health Insurance Claim Form

For Group Insured Member Only

I hereby express intention to claim medical expenses from Muang Thai Life Assurance Public Company Limited with the following information for consideration.

Name of Policyholder (Company Name):	Date:
Group Policy No.:	HealthCare Card No.: G-A☐☐-☐☐☐☐-E☐☐☐☐☐☐☐-☐☐
Name – Surname of Patient:	Age: Years Old / Gender: ☐ Male ☐ Female
Present Address:	
Contact Mobile Phone No.:	E-mail:

Type of Treatment: ☐ Inpatient (IPD): Date of Admission..... Date of Discharge.....
☐ Outpatient (OPD) ☐ Dental Date of Treatment.....
☐ Others (Please specify) ..... Date of Treatment.....

Cause: ☐ Illness ☐ Accident Date of Accident .....Time..... Any Police Report? ☐ Yes, reported at ..... ☐ No
Descriptions of Incident: .....

Are you eligible for compensation from other companies? ☐ Yes, please specify ..... ☐ No

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.

Sign ..... ( ) Personal data provider / Insured / Legal representative	Sign ..... ( ) Witness	Sign ..... ( ) Witness

* Sign ..... Consent grantor Relationship.....
( )

Remarks: 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 parent 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 parent is required to sign together with the minor and specify the relationship.

Scan for details of Privacy Policy