Allianz Insurance Lanka Limited
Company No PB 5179
No. 675, Dr. Danister de Silva Mawatha, Colombo 09.
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ACCIDENT AND SICKNESS CLAIM FOR TRAVEL COMPANION

INSTRUCTION

1. This form is to be used when filling a claim for reimbursement of Medical Expenses.
2. Section "A" must be completed by the insured in full.
3. Following to be provided:
   - 3.1 Section "B" to be completed by the attended physician.
   - 3.2 Itemized bills with: claimant's name/nature of illness/injury, summary of treatment and charge for each service.
4. This form must be signed and dated in all applicable sections.
5. This form and all attached bills must be submitted to the Policy issuance office.

The furnishing of this form or it's acceptance by the Company, must not be construed as an admission of any liability on the company, nor a waiver of the conditions of the insurance contact.

Policy No:..... Plan: .....
Is Allianz Global assistance authorization obtained? Yes. ☐ No. ☐ If yes AGA's Reference No:.....

SECTION A

1. Name of the Insured :.....
   Insured's Date of Birth : ☐☐☐☐☐☐☐☐ Gender: Male ☐ Female: ☐
2. Name of the Claimant :.....
   Claimant's Date of Birth : ☐☐☐☐☐☐☐☐ Gender: Male ☐ Female: ☐
3. Current Residence Address:.....

   Telephone – Home: ☐☐☐☐☐☐☐☐☐☐ Mobile: ☐☐☐☐☐☐☐☐☐☐

   Email :..... Credit Card No: ☐☐☐☐☐☐☐☐☐☐
4. Date of Arrival in Country: ☐☐☐☐☐☐☐☐ Date to return to Sri Lanka: ☐☐☐☐☐☐☐☐
5. If Accident, provide details i.e. how, when and where accident occurred :.....
   .....
   .....
6. If sickness, advise what and when symptoms first occurred: .....
   .....
   .....
7. Name and address of Consulting Physician (s):.....
   .....
8. Have you ever been treated for this illness before? Yes. ☐ No. ☐
   If yes, provide name and address of treating Physician (s) and date (s) of first Consultation: .....
   .....
9. Provide Name and Address of your family Doctor/Specialist:.....
   .....
10. Please list name of medications you are presently taking :.....
    .....
11. Please furnish details of any Health Insurance policy you are holding :.....
    .....

Authorization

The undersigned authorize an y hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agent group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the insurance company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provide to, person whose death. Injury, sickness or less is the basic of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payment under the Policy Number identified above. I authorize the group policyholder, employer or benefits plan administrator to provide t he Insurance Company named above with financial and employment- related information. I understand that this authorization is valid for the term of coverage of the policy identified above and that a copy of t his authorization shall be considered valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

…… ……

Signature of claimant or Parent, if claimant is minor Date

I hereby certify that the above information is true and correct to the best of my knowledge.

…… …… ……. ……

Signature Date

SECTION B

ATTENDING PHYSICIAN'S STATEMENT

To be completed by the Doctor/s consulted while traveling overseas. Policy No (Specify the digits) :…….

1. Name of injured p a t i e n t :……
2. Address :…… .....
3. Age:…… 4. Occupation:……
5. Please state nature of the disease/accident in detail:……
6. Does the cause of disease/accident as stated by the claimant tally with your examination findings Yes. ☐ No. ☐
7. Are the injuries solely due to the accident or traceable to any previous injuries/disease? Yes. ☐ No. ☐
8. Was the injured person suffering from any disease or injury, which may have contributed to the accident or likely to aggravate his condition? Yes. ☐ No. ☐
9. Please mention past history of any diseases, accident or Hospitalization with details:…… ……
10. Was the claimant hospitalized during the current event? Yes. ☐ No. ☐
    If so for what period:…… .....
11. Please give detail of the treatment given and operation/surgical process performed:…….. ……
12. List all dates of treatment: from …… to……. Outpatient clinic/Hospitalization:…….. .....
13. Was the patient under influence of intoxicant or drugs:……
14. Are you his usual medical attendant? Yes. ☐ No. ☐
    If you have treated him for any previous illness or injury, please give details:……
    How long do the records that you hold go back?.....
15. Have other doctors been in attendance or consulted? Yes. ☐ No. ☐
    If yes, please give details. When was the medical advice last sought and why?:…… ……. .....
16. Has this accident been reported to Policy? Yes. ☐ No. ☐
    If yes, please mention The Case No. and Police advise last sought and why? :…… .....
17. Is this claimant in your option totally disabled from each and every occupation? Yes. ☐ No. ☐
    How long the claimant is away from his/her Duty?:……
18. What is the Prognosis:…… ..
19. Doctor's Name, Address and Tele phone No: ……..

Doctor's Signature:…… Date of Visit :
……