Phillip General Insurance
Your Partner In Insurance
A Member of PhillipCapital Group, Singapore

HOSPITAL & SURGICAL CLAIM FORM

TO BE COMPLETED BY THE INSURED PERSON

1/ POLICYHOLDER INFORMATION

Name	Policy Number

2/ CLAIMANT INFORMATION

Name	Phone Number
Occupation	Address
Date of Birth	Gender

3/ DETAILS OF ACCIDENT

Time & Date of Accident	Place of Accident
Explain How the Accident Happened	
Describe the Nature of Injuries:	

4/ DETAILS OF SICKNESS

Time & Date of Sickness	Diagnosis
Has the insured person ever seen a doctor or been treated for any similar conditions in the past? Yes ☐ No ☐ If "Yes", please state date of previous treatment and name and address of attending doctor:	

5/ OTHER INSURANCES OR NSSF

Question	Yes		No	
Do you have any other insurances or NSSF cover this accident or sickness?	Yes	☐	No	☐
If "Yes", did you submit the claim to them? Please give us the details of the insurance policy and the insurance company:	Yes	☐	No	☐

6/ CLAIM AMOUNT AND CHEQUE PAYEE NAME

Claim Amount	Name of Cheque Payee

7/ DECLARATION BY CLAIMANT

I declare that I have complied with the conditions and warranties of the Policy and in no manner deliberately caused the said loss or damage or exaggerated the claim or sought unjustly to benefit any fraud or willful misrepresentation and that the information shown on this form is true and correct to the best of my knowledge and belief and that I have not concealed any information relating to this claim. I understand **Phillip General Insurance (Cambodia) Plc** reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.

I authorize the release of any medical information necessary to process this claim.

DATE	**NAME**	**SIGNATURE & STAMP**

TO BE COMPLETED BY THE ATTENDING DOCTOR

1/ PATIENT INFORMATION

Name	Age Sex
Time & Date of Admission	Time & Date of Discharge
In-Patient ☐	Out-Patient ☐

2/ DETAILS OF DIAGNOSIS

Please indicate the diagnosis of all the conditions treated and give a description of the symptoms of illness or injury:
What was the cause(s) of the injury/illness?
Has the patient ever had the same or any similar conditions? Yes ☐ No ☐ If "Yes" please state when and describe:

3/ DETAILS OF SURGERY TREATMENT

Is the surgery/treatment for cosmetic reasons? Yes ☐ No ☐
Type of Operation / Surgical procedures performed

I confirm and certify that the above details are true and correct.

DOCTOR'S NAME	**PHONE NUMBER**	**DATE**

ADDRESS	**DOCTOR'S SIGNATURE & CLINIC OR HOSPITAL STAMP**