INSTRUCTION FOR HEALTHCARE CLAIM PROCESS

Please kindly follow the instruction as below:

1. Collect claim documents:

- Please kindly collect all required documents (*) as the end of this page.

2. Send the claim documents to PCV via one of these below methods:

2.1. Send the image files:

- Take a picture/ scan all the claim document with best quality image (**).

- Send your claim pictures or scanned copy to claimsubmission@pacificcross.com.vn.

- You will receive an auto-reply confirmed email immediately after that.

2.2. Send the claim document direct to PCV office (Hanoi, Ho Chi Minh) following the address at the bottom of this page.

3. Receive claim's result within 5 working days:

(after submitted fulfill claim documents and information as required)

- In the case your claim document does not have enough information/ documents, PCV will send an email to instruct you provide the additional information/ documents for completing the claims process.

Notice:

(*) Below are the required documents for claim processing:

- Claim form: please kindly fulfill all information, sign and send **the original** form to PCV.
- Medical report/ Medical book/ Test result/ Treatment plan/ Doctor's indication note: picture/ image/ photocopy.
- Discharge summary (for Inpatient case): picture/ image/ photocopy.
- Prescription: picture/ image/ photocopy.
- Breakdown of charges: picture/ image/ photocopy.
- Legal financial invoice sent to PCV:
  + **The original** VAT invoice and converted e-invoice in paper.
  + Non-converted e-invoice (**.pdf**) **with code and link for searching**.
- Other document(s) or information might be required in specific case.

(**) Pictures or scanned document must be in color and readable. Time of claims processing can be influenced if any file is not able to read. The claimant is asked to retake the clear version.

Please note: Pacific Cross Vietnam (PCV) has the right to re-adjudicate if information on hardcopy and the photo or image PCV received are not coincided.

CLAIMS DOCUMENT REQUIRED FOR TRAVEL PLAN

Please inform us your claims and submit related documents via phone calls and email within 30 days from expiry date of Travel Policy Package.

GENERAL DOCUMENT

- Fulfilled claims form.
- Travel Certificate.
- Health Insurance Card (if applied).
- Copy of full Passport, Visa.
- Copy of Boarding Pass.
- Information of reservation/booking.

SPECIFIC DOCUMENT

1. "Baggage and personal effects" benefit:

- Incident report (describe date and time, place, cause of loss/ damage) verified by carrier/ local Police Department/ authorized organizations. Claimant must immediately report and loss/ damage to the proper authorities having jurisdiction at the place of loss or damages (within 24 hours).
- Confirmation in writing of carrier or other liable parties on amount recoverable.
- List of lost/ damage items, including details of description, specification, quantity, actual cash value and amount of loss or damage.
- Document to prove the value of lost/ damaged items (such as original invoices).
- Original quotations/ invoices for preparation or replacement or re-issuance (Passport, Visa) with relevant date.
- Document to prove the replacement is essential.

2. "Baggage delay" benefit:

- Travel itinerary.
- Property irregularity report from carrier (Baggage Claim form).
- List of emergency purchase of essential clothing and toiletries and original purchasing invoices.
- Receipt of acknowledgement on returned baggage from the carrier.

** Note: only considered if the event took place overseas.*

3. "Curtailment of trip/Trip cancellation charges" benefit:

- Estimated schedule of original trip.
- Breakdown report of the portion of the original trip that was not utilized.
- Document confirming amount refunded and relevant cancellation charges by carrier.
- Ticket purchase invoice.
- Invoice of any amount paid in advance (pre-paid).

- Hotel invoice and statement for accommodation.
- Invoice of replaced vehicle for transportation.
- Health record/ Death certificate/ Court report or Center for Disease Control and Prevention (CDC) if the cancellation comes from Death event/ Severe illness or Disability/ Compulsory witness or Isolated in pandemic.
- Support document to prove relationship between the insured and the relatives.

4. "Travel Delay/Mistransit" benefit:

- Estimated schedule of original trip.
- Information of reservation/ booking (flight information, time of departure, flight number, passenger name,…).
- Notification from the carrier confirming date and time, duration and reason for the delay.

5. "Medical expenses/Personal accident" benefit:

- Health record regarding claims of medical expenses/ personal accident (describe the nature and level of disabilities; time and duration of disabilities happen).
- Appraisal of disabilities verified by authorized organizations.
- Investigation report verified by Police Department (if any).
- Death certificate (for Death event).
- Tests result.
- Surgery certificate (if treated by surgery).
- Breakdown of medical charges.
- Emergency Assistance fee such as ambulance… (accepted by Hung Vuong Insurance).
- Other original invoices.

6. "Personal liability" benefit:

- Report indicating the nature, time, place and circumstance of the incident or event.
- Estimated claims amount.
- Related document and contact information of any third party.
- Writting, summon or other notice of legal proceeding from any third party or lawyer (if any).

PACIFIC CROSS VIETNAM

The strength behind your insurance

TRAVEL INSURANCE CLAIM FORM

Claim No. (Office use): _____

Please send all claims and inquiries to **Pacific Cross Vietnam**.

A. PARTICULARS OF CLAIMANT

Insurance Certificate No.: _____

Name of Claimant: _____ Date of birth (day/month/year): _____

Postal Address: _____

Passport or Government I.D. No.: _____

Phone No.: _____ Fax No.: _____ Email: _____

B. Please check the appropriate box and submit the required documents as per the claim procedures of the Company.

- ❑ Medical Expenses and Emergency Assistance Benefit (*Please fill out* **Attending Physician's Statement Form** *found at the back)*
- ❑ Hospital Cash Allowance
- ❑ Additional Costs of Travel & Accommodation
- ❑ Family Member Visit
- ❑ Return of Children
- ❑ Personal Accident Benefit
- ❑ Mortal Remain Benefit
- ❑ Baggage and Personal Effect
- ❑ Baggage Delay
- ❑ Loss of Travel Document
- ❑ Personal Money
- ❑ Travel Delay
- ❑ Curtailment of Trip or Cancellation

C. Please give a short description of the circumstances giving rise to your claim (If space is insufficient, please attach additional details.)

Benefit: _____
Details: _____

Benefit: _____
Details: _____

D. OFFICIAL RECEIPTS SUBMITTED (If space is insufficient, please attach additional details.)

Official Receipt Number	Details of Payment *(professional fees, medicines, baggage, etc.)*	Amount *(pls. specify currency)*
	TOTAL	

E. CLAIM PAYMENT DETAILS

- ❑ Cash
- ❑ Bank Transfer (please fill in the VND bank details below)

Account Holder's Name: _____ Account No.: _____

Bank Name: _____

Bank Address: _____

F. AUTHORITY and DECLARATION STATEMENTS

Authority: I hereby authorize any licensed physician, medical practitioner, hospital, clinic, insurance company or other medical or medically related facility who has attended me to furnish to insurance company (or its representative) and permit the said insurance company (or its representative) to review any and all information requested with respect to any illness or accident, medical history, consultation, prescription, or treatment and copies of all hospital or medical records and the records of any governmental agency with which a report of any such accident or illness is lodged. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

Declaration: I, the undersigned, hereby declare to the best of my knowledge and belief that the particulars stated on this form to be true and correct. I understand that if I fail to provide any information requested in this form, it may result in the inability of the Company to accept or process this claim.

_____ _____

Date (day/month/year) Signed (Claimant or Parent if a minor)

ATTENDING PHYSICIAN'S STATEMENT

❑ **OUT-PATIENT**
Date of Consultation: _____

❑ **IN-PATIENT**
Date Admitted: _____ Time: _____
Date Discharged: _____ Time: _____

(A) Diagnosis/es	(B) Date when symptoms first	(C) Date of first consultation for the condition	(D) Previous treatment done for the symptom / dianosis	
			Treatment Date	Name of Doctor & Hospital
1.				
2.				
3.				
4.				

(E) If condition is a complication, date when symptoms of its cause started (day/month/year): _____

(F) Name of Surgical Intervention (if any): _____
Any required post-operative consultations? ❑ Yes ❑ No If Yes, specify consultation dates: _____

(G) Any other disease or infirmity affecting present condition? ❑ Yes ❑ No
If yes, please describe: _____

(H) Is condition due to Dental problem, Pregnancy, Childbirth, Miscarriage or Sickness originating there from?
❑ Yes ❑ No If yes, please note the cause: _____

(I) Is the diagnosis in any way related to the ff: congenital/heredo-familial conditions/developmental abnormalities/ birth defects/obesity? ❑ Yes ❑ No

(J) Do you consider this consultation as a continuous treatment for a chronic disease? ❑ Yes ❑ No

(K) Is this a Routine General Medical Examination or Vaccination? ❑ Yes ❑ No

(L) Is this condition accident-related? ❑ Yes ❑ No If yes, when did the accident happen? _____
Around what time: _____ What was the nature of the accident? _____

(M) Is Physiotherapy recommended? ❑ Yes ❑ No

(N) For Out-Patient: Is the condition related to a previous confinement? ❑ Yes ❑ No
If yes, specify confinement date: _____

Hospital: _____
Tel. No.: _____ Fax No.: _____
Address: _____

_____
Signature over Printed Name of the
Main Attending Physician / Surgeon