**บริษัท อาคเนย์ประกันชีวิต จำกัด(มหาชน)**

**แบบฟอร์มการเรียกร้องค่าสินไหมกรณีผู้ป่วยนอก(การรักษาทันตกรรม)**

# Outpatient (OPD) Claim Form (Dental)

**Group Insurance**

## ส่วนที่ 1 สำหรับทันตแพทย์ที่ทำการรักษาเป็นผู้กรอก

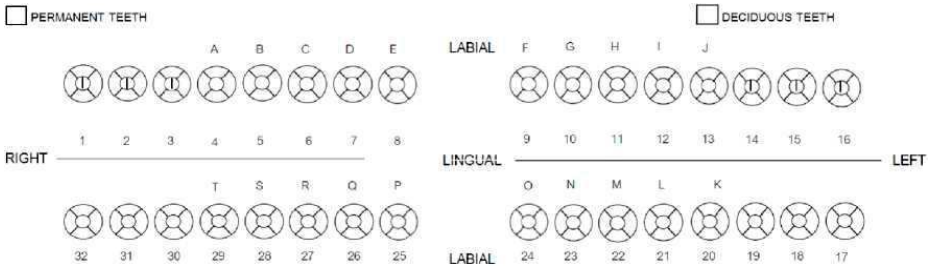
TO AVOID RETURN OF CLAIM DUE TO INCOMPLETE INFORMATION, PLEASE ANSWER ALL QUESTIONS.

| | | |
|---|---|---|
| NAME OF PATIENT: | AGE: | SEX: |
| TO BE COMPLETED BY ATTENDING DENTIST. | | |
| DENTIST NAME: | DENTIST LICENSE NO: | |
| PLEASE ANSWER AS COMPLETED AS POSSIBLE.<br>If prosthesis, is this initial placement? | IF YES, PLEASE GIVE BRIEF DESCRIPTION AND DATES.<br>Date of Rx: | |
| Is treatment for orthodontics? | Date of Rx: | |
| Is treatment a result of accident? | Date of Rx: | |

Please fill in the for oral treatment (including X-rays, prophylaxis, material used,etc.):

| Tooth No. | Particulars | Charges |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |

Please mark teeth treated or area of oral treatment on following chart.




I hereby certify that the services listed above have been performed on the above-named patient on the date indicated.

Dentist's signature: _____ Hospital/Clinic: _____ Date _____

( ) ประทับตรา รพ./คลินิค

## ส่วนที่ 2 สำหรับผู้เอาประกันภัยเป็นผู้กรอกโดยสมบูรณ์ (For the Insurance Person)

**LETTER OF CONSENT**

I, hereby, consent and allow doctors, medical centres, other insurance companies or any relevant persons who have acquired my personal information, health, medical records, disability, sexual behaviour, biometric data, genetic data, and my past or future medical history which were available or will be available to disclose and release such information to the Company, the Company's life insurance agents, or the Company's representatives in order to apply for an insurance policy, or claim the benefit thereof, or dealing with the insurance policy in any manner.

I, hereby, grant my consent to the Company to collect, use, disclose and release my personal information, health, medical records, disability, sexual behaviour, biometric data, genetic data, and my past or future medical history to the competent authorities or the reinsurers, relevant persons, the Company's life insurance agents, its personnel, and its representatives for the purpose of applying for an insurance policy, indemnifying the insured person thereunder, or for medical interest or dealing with the insurance policy in any manner.

In the event of a claim of indemnification through a hospital, I, hereby, consent and allow the Company to pay the medical fees to the medical centres from which I have received the treatment as if the Company has legally indemnified me of such expenses under the terms and conditions of the insurance policy. Nevertheless, I will directly and personally make payment of any outstanding medical fees which are not covered by the insurance policy. Also, I fully appreciate that the Company reserves the rights to indemnify according to the campaign of payment of the medical expenses through hospitals if the illness or accident which I am claiming found to be exempted under the insurance policy despite the Company's preliminary approval of my inpatient treatment. In this case, I shall reimburse the Company of all expenses it has advanced to the medical centre on my behalf within 7 (seven) days from the date of the notice by the Company.

Additionally, the copy of this Letter of Consent shall be binding as same as the original.

I, hereby, fully acknowledge and understand the content as well as conditions and the practices of the Company. I also agree that they are in accordance with my intention. Therefore, I am thereby entirely bound without reservation.

Insured: ..... Date: ..... Witnesses signed to certify fingerprint 1: ..... 2: .....

(.....) (.....) (.....)

Consented by (in case the insured is under legal age): ..... Relationship: ☐ Father/Mother ☐ Legal guardian

(.....)

**Remarks:**

- In case the insured is juvenile under the age of 10 years: Single signature from either father, mother or legal guardian is required.
- In case the insured is juvenile over the age of 10 years: Signatures from both the insured and either father, mother or legal guardian are required with the relationship specified.
- If the fingerprint is provided, please specify details of which finger and on which hand side, with signatures from 2 witnesses.