Forte
Life Assurance

Forte Life Assurance (Cambodia) Plc
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Mao Tse Tung Blvd, Sangkat Toul Svay Prey 1, Khan
Beong Keng Kong, Phnom Penh, Kingdom of Cambodia.
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Claim Form

For Accident, Hospital, Waiver of Premium, Disability Loss, Total and Permanent Disability and Death
This form must be completed by the person who has a claim on the proceeds of the insurance as the policy owner, beneficiary, next of kin, or the legal and personal representative. This form is issued by **Forte Life Assurance (Cambodia) Plc** without admission of liability and must be returned to the us to our Head Office or any of our Branch Offices.

The benefits under the insurance Policy shall be paid to the Policy Owner. If the Policy has been assigned, or where the ownership has been transferred to another, and only if the assignment or transfer is registered with us during the life time of the Life Assured, will the interest of the such on record with us have precedence over any Owner or Beneficiary. The Assignment or transfer of ownership is a contract between the Policy Owner (Assignor) and the Assignee. We are not responsible for the validity of any such assignment. Only assignments received during the life time of the Life Assured will be registered by us.

What to do in the event of a claim
Notify us immediately upon occurrence of a claim event. Call us or our representative who will help you to provide us with a with a Notice of Claim. This Notice briefly provides us with information regarding the claim event, date of event and the loss resulted. You are required under the terms and conditions of your insurance to provide notice of the event resulting in claims immediately upon occurrence.
To safeguard your interest, please ensure that you complete and return this form within thirty (30) days as it is a condition for us examine the claim and determine our liability. If we receive no response from you after 12 months from the issuance of this Claimant's Statement, we will deem that you are no longer interested in your claim and our liability shall be expired.

Your Claims will normally be paid within 10 days of our receipt, provided all required documents are submitted to us. However, if we require further verification of the documents or investigation of the Claims we will inform you.

If you need any clarifications, assistance please contact us through our telephone helpline number
(+855) 98 802 802 or Email info@fortelifeassurance.com

At Forte we value your feedback on our services. It helps us build better processes for your service experience.

Section A: Life Assured's Information

Complete this Section for all Claims

a. Name:	English:	Khmer:	
b. Insured's ID	ID Number: Please state: Identity Card/passport/ birth certificate/other		
c. Policy Number:	1.	2.	3.
d. Type of Claim: Please state: /accident/loss of limb/hospital/ premium waiver/ Total and Permanent Disability/critical illness/ death.	☐ Accidental Injury ☐ Loss of limb ☐ Hospital (complete Part 2) ☐ Premium Waiver ☐ Total and Permanent Disability ☐ Critical Illness (please use forms for the specific Critical Illness) ☐ Death (please complete Claimant's Statement)		
e. Insured's Contact: By providing us your contact you consent to allow us to serve you through these means.	Contact numbers: Email Address:	Address:	
Occupation: Please give details of your occupation in the box on the right.	1. Position held: 2. Duties: 3. Nature of Business:	Name and Address of Employer:	
Insurance from other sources: Please add pages if space is insufficient. *CI or Critical illness	Name of Insurer/Life, Hospital, CI* or Accident/Sum Assured/year of issue		
	1.		
	2.		
	3.		

Section B: Hospital Claims

Complete this part if claim is for Hospital, Medical, Critical Illness

a. What is diagnosis of the condition claimed for?			
b. What are the signs and symptoms?			
c. How long were you aware of the condition?	Please give date or how long ago you first had consultation or treatment.	**d. When did you first notice symptoms of this condition?**	

e. Were you warded or hospitalized for your condition? If 'Yes', please dates of hospitalization.	Yes No Dates confined to hospital: dd/mm/yyyy to dd/mm/yyyy dd/mm/yyyy to dd/mm/yyyy	**f. Please attach Medical Report and Hospital Discharge Certificate**	
g. Are you still under follow up, consultation, or medical advice?	Yes No		

h. Please give names and address of doctors and hospitals you have ever consulted for this and any other condition. *If space is insufficient, please add additional names to Section G*	Name of Doctor/Hospital	Address	Reason for Consultation
	1.		
	2.		
	3.		

Section C: Accidental Injuries/Loss of Limb

Complete this section for accidental injuries, Partial Permanent Disability, Loss of/loss use of Limbs

a. Please give the date and time of accident	Date: Dd/mm/yyyy	Time: XX.XX am/pm
b. Where did the accident occur?	Place of accident	
c. Please give details of the events leading to the cause of accident and injuries.		
d. Describe injuries sustained		
e. Please give names and addresses of Doctors and Hospitals you have consulted or admitted.	1.	
	2.	
f. Was a police report made? Yes No	If 'yes' Please attach a copy of the report	
g. Are you making any claims from other insurance companies? Yes No	If 'Yes' please give names of insurance companies below:	
h. What was for last day of work before the Accident?		
i. When did you go back to work?		

Section D: Total and Permanent Disability Claims

Complete this Section for Life Assured (Total & Permanent Disability) or Policy Owner (for Premium Waiver)

Question	Response
a. Please give names and addresses of Doctors, Clinics and Hospitals who are treating you for your condition.	Names of Doctors/Clinics/Hospitals Please attach a medical report by your attending doctors. Note: Further medical evaluation may be required by our appointed doctors
b. What are your usual duties before you had the accident or illness?	Describe your usual duties
c. Are you capable of resuming all your usual duties? Yes No	Please describe all the duties that you can no longer perform
d. Are you able to move about without any aid or the assistance of a third person? Yes No	If unable to, please describe any assistance of any walking aids, crutches, prosthesis, wheel chair etc.
e. Have you been medically boarded out by your Employer? Yes No	If 'Yes', please state date you were medically boarded out.
f. Are you now engaged in any other occupation and do you have any other sources of income? Yes No	If 'Yes', please describe these occupation(s) and sources of income.

Section E: Death Claims

Complete this section only for Death Claims on the Life Assured or Waiver of Premium Claims on the Policy Owner

Question	Response
a. Please give date and time of death of the Life Assured?	Date of Death: dd/mm/yyyy Time of death ……………… am/pm Please attach a copy of the Life Assured's Death Certificate
b. Please give the place of death.	
c. What was the cause of death?	
d. If the cause of death was due to accident, please describe the events leading to the accident and death of the Life Assured.	

<table>
<tr><td>e. Was a police report made?
Yes No</td><td colspan="2">If ‘Yes’, please attach a copy of the police report.</td></tr>
<tr><td rowspan="3">f. Has the Life Assured suffered from any other illness previously?
Yes No

If space is insufficient, please the same details under Section G below.</td><td colspan="2">If ‘Yes’, please describe below these illnesses and how long has the Life Assured suffered from them</td></tr>
<tr><td>1.</td><td>dd/mm/yyyy or how long ago</td></tr>
<tr><td>2.</td><td>dd/mm/yyyy or how long ago</td></tr>
<tr><td>g. Give the name and address of the Life Assured’s last medical doctor?</td><td colspan="2">Name of Doctor/Address</td></tr>
<tr><td>h. Does the Life Assured have any other medical doctor for this or any other illness?</td><td colspan="2">Name of Doctor/Address</td></tr>
<tr><td colspan="3">Complete this Sub-Section below only if there is no named beneficiary under the Insurance Policy</td></tr>
<tr><td>i. What is the marital status of the Life Assured at the point of death?</td><td colspan="2">☐ Single
☐ Married
☐ Divorced
☐ Widow/Widower</td></tr>
<tr><td>j. Does the Life Assured have any living children, and any adopted or unborn children who may have a claim on the benefits of the insurance? Yes No</td><td colspan="2">Please give details of any such these children below:</td></tr>
<tr><td>k. Did the Life Assured leave a last will and testament?
Yes No</td><td colspan="2">Please give details of any such Will</td></tr>
</table>

Section F: Claimant(s) Information

Complete this Section for death claims on the Life Assured is also the Policy Owner of the insurance policy.

In the absence of any assignment or transfer of ownership of this policy, death benefits will be paid to the named Beneficiary(s), according to their respective shares. Where no shares are allocated, then beneficiaries share equally. Where no beneficiaries are named, or if the beneficiary dies before the Life Assured, then persons described under Section C of the Civil Law Act may claim the benefits according to their order of priority. If there is more than one claimant, please provide information for each individual claimant as required below.

Proper Claimant's name Please give name in English and Khmer Unicode (if any)	**Capacity*** Please state your claim as: Assignee Beneficiary/legal Guardian/Legal and Personal Representative	**ID type and Number** Please state if National Registered ID/Passport/Birth Certificate	**Relationship to Life Assured** Please state as: Spouse, Child or Parent, or Other (please specify)	**Contact Details**** Please give: a. Contact Number b. Email: c. Address:
Claimant 1				
Claimant 2				
Claimant 3				

Space for 3 Claimants is provided. If space is insufficient, please give the same information required for further each Proper Claimants under Section G of this form.

* An underage claimant may be represented by his/her parent or legal guardian. Please give names and details of both the Claimant and the Parent/Guardian under the same row above.

**By providing your contact number and email you consent to allow us to serve you through these means.

Section G Space for Additional Information

Please quote Section and Question Number before giving details as Specified.

Section/Question Nos.	

Section H Documents Attached with Claims Form

Please attach proof of your claim as specified below

Hospital, Accidental Injuries, Total & Permanent Disability	Death Claims
☐ Medical Report ☐ Hospital Discharge Certificate ☐ Police Report (if any)	☐ Last Doctor's Medical Report ☐ Police Report (if death due to accident) ☐ Autopsy Report (if death due to accident or suicide)

Declaration and Authorization

I declare that I am the proper Claimant for the insurance benefits and/or authorized on behalf of other claimants to make this claim. I declare that I have answered the above claim form fully and faithfully and have not withheld any information which is material to the validity of the claim. I understand that Forte Life Assurance (Cambodia) Plc (FLACP) shall have the right to deny any liability or recover any claim paid if any part of the information is untrue, incomplete or incorrect.

I agree that FLACP in discharging its duty may transfer or disclose information regarding the insurance claims to its reinsurers, claims investigators, insurance associates and insurance association member companies, doctors, hospitals, clinics, and intermediaries and third party service providers who are tasked to provide services to it.

I further authorize any Doctor, Medical Professional, Specialist, Hospital or Clinic, and any other organization that has information regarding the Life Assured medical information to release the said information to FLACP. A copy of this authorization is as valid as the original and be legally binding to anyone who takes over my rights, as well as the rights of the Life Assured.

Authorization for Medical Report Release and Collection

I, _________________________________ bearer of ID Card number_________________________ the proper Claimant/Policy Owner of the insurance policy insuring the life of _________________________ who is the Life Assured, with ID number _________________________ do hereby agree and authorize Forte Life Assurance (Cambodia) Plc. a company registered in the Kingdom of Cambodia to procure and collect on my behalf any medical record or information on the Life Assured for its own use solely for the purposes stated above.

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Signature of Policy Owner/Assignee

Name:

ID Number:

I hereby attest that the above signature was made in my presence.

____

Signature of Witness

Name:

ID number: Address:

Contact number:

Witness must be an Authorized Person of FLACP, its Consultant or Authorized Intermediary and above 18 years old.