



Insurance

GAN Assurances IARD

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NOTICE OF CLAIM UNDER MEDICAL AND SURGICAL BENEFITS POLICY
(The issue of this form constitutes no admission of liability)

INSURED: \_\_\_\_\_

POLICY NO. \_\_\_\_\_

CLAIMANT: \_\_\_\_\_

EXPIRES ON: \_\_\_\_\_

PLEASE NOTE: INFORMATION BELOW TO BE COMPLETED BY MEDICAL DOCTOR

Form with 4 numbered sections for medical information: 1. Nature of illness or condition giving rise to the claim; 2.a. When and where did symptoms of this first appear?; b. Is condition chronic or likely to reoccur?; 3. Name and address of medical attendant, to whom the Company may apply for any further information.; 4. Has the patient previously suffered from, or been affected by, this illness or condition?

I hereby declare that no material information nor circumstances touching my Patient's illness/condition has been withheld; and I warrant the foregoing statements to be true in every respect.

Date.....

Signed by Dr. ....

Signed by Claimant .....