

Authorization

The undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agent group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the insurance company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provide to, person whose death. Injury, sickness or less is the basic of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payment under the Policy Number identified above. I authorize the group policyholder, employer or benefits plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the policy identified above and that a copy of this authorization shall be considered valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

.....
Signature of claimant or Parent, if claimant is minor
I hereby certify that the above information is true and correct to the best of my knowledge.

.....
Date

.....
Signature
Date

**SECTION B
ATTENDING PHYSICIAN'S STATEMENT**

To be completed by the Doctor/s consulted while traveling overseas. Policy No (Specify the digits) :.....

1. Name of injured patient :.....
2. Address :.....
3. Age :..... 4. Occupation:.....
5. Please state nature of the disease/accident in detail:.....
6. Does the cause of disease/accident as stated by the claimant tally with your examination findings Yes. No.
7. Are the injuries solely due to the accident or traceable to any previous injuries/disease? Yes. No.
8. Was the injured person suffering from any disease or injury, which may have contributed to the accident or likely to aggravate his condition? Yes. No.
9. Please mention past history of any diseases, accident or Hospitalization with details:.....
10. Was the claimant hospitalized during the current event? Yes. No.
If so for what period:.....
11. Please give detail of the treatment given and operation/surgical process performed:.....
12. List all dates of treatment: from to.....Outpatient clinic/Hospitalization:.....
13. Was the patient under influence of intoxicant or drugs:.....
14. Are you his usual medical attendant? Yes. No.
If you have treated him for any previous illness or injury, please give details:.....
How long do the records that you hold go back?.....
15. Have other doctors been in attendance or consulted? Yes. No.
If yes, please give details. When was the medical advice last sought and why?:.....
16. Has this accident been reported to Policy? Yes. No.
If yes, please mention The Case No. and Police advise last sought and why? :.....
17. Is this claimant in your option totally disabled from each and every occupation? Yes. No.
How long the claimant is away from his/her Duty?:.....
18. What is the Prognosis:.....
19. Doctor's Name, Address and Telephone No:

Data Privacy

Please ensure to go through the Privacy Notice (i.e. which explains how and what type of personal data will be collected, why it is collected and to whom it is shared or disclosed etc.) which is available on the Allianz Insurance Lanka Limited/AllianzLife Insurance Lanka Limited official website <https://www.allianz.lk/data-privacy-notice.html> prior to signing of this form/ application/ document.

Doctor's Signature:.....

Date of visit:.....

Adopted Date: 09/09/2014 nr.