เมืองไทยประกันชีวิต
MUANG THAI LIFE ASSURANCE
บมจ. เมืองไทยประกันชีวิต
250 ถนนรัชดาภิเษก เขตห้วยขวาง กรุงเทพฯ 10310
Muang Thai Life Assurance PCL
250 Rachadaphisek Rd. Huaykwang, Bangkok 10310
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muangthai.co.th

Date .....

Claim for Total and Permanent Disability Benefits

☐ Name-surname of insured who has total and permanent disability.....
According to the insurance contract No. .....
☐ Name-surname of premium payer who has total and permanent disability.....
According to the insurance contract No. .....

Name - surname of caretaker/curator (if any).....
Current address.....

a. Type of benefits requested
☐ Total and Permanent Disability benefit due to accident/illness on .....Caused by .....
☐ Waiver of premium

b. Information of disability
1. Date showing first disability condition.....Caused by ……..……..
Condition…….....……Medical center giving treatment……..……..…..…..
2. Date of last appointment with physician……..……..…….....Condition…….....
..... Medical center giving treatment……..……..…….....
3. Total number of days away from work …….....……
4. Medical center that you received treatment of such disability

Name of Medical center	From	To	Treatment Result

c. Documents for claim request
☐ Copies of all medical records from medical center …….....……..…….....
☐ Others …….....

d. Is an insured person/premium payer entitled to receive compensation from other companies? ☐No ☐Yes, please specify……..…….....

e. Claim/Compensation collection channels ☐ Transfer to the bank account given to the Company only
☐ Receive at the Head Office of Muang Thai Life Assurance PCL
☐ Receive at Muang Thai Life Assurance PCL, Branch…….....……..……..……..……..……..…….
☐ Via agent, Name …… Team/Department ……..…….....
☐ Direct mail to the current address

Declaration and Authorization of Medical Record Disclosure

With this letter, I hereby give consent to the attending physician(s) or hospital(s) or any medical center(s) that has provided or used to provide me/an injured person/a sick person with medical treatment to disclose the medical record or other details pertaining to the treatment and health checkresult to Muang Thai Life Assurance Public Company Limited I authorize Muang Thai Life Assurance Public Company Limited or a representative of the Company to act as a legal representative to proceed and contact to receive the afore-mentioned medical record from the attending physician(s) or hospital(s) or any medical center(s) that has provided or used to provide me/an injured person/a sick person with medical treatment as if they were my own actions in all respects. A photocopy or copy of this authorization is regarded as equally effective and complete as the original.

Sign…….....Insured person/Premium payer
( )

Sign…….....Caretaker/Curator
( )

Sign…….....Witness
( )

Sign…….....Witness
( )

Remark: In case of signing by fingerprint, signatures of 2 witnesses must be completely provided.

Comments from Physician Certifying Disability

Name-surname of patient…….....H.N. ……..... A.N. ……..…..

Date showing first disability condition…….....……. due to …….....……

Other existing underlying diseases…….....

Period of illness, started since…….……..... Medical center giving treatment……..…….....……

a. Assessment of impairment

1. Ability to perform activities of daily living

1.1 Taking a bath	( ) Able to wash oneself	( ) Need assistance from others
1.2 Dressing	( ) Able to put on or take off tops and pants	( ) Need assistance from others
1.3 Feeding	( ) Able to eat food by oneself	( ) Need assistance from others
1.4 Continence	( ) Able to control their bowel and bladder function	( ) Show incontinence of such function
1.5 Mobility	( ) Able to move from place to place	( ) Need assistance from others

2. Level of consciousness ( ) Good ( ) Confused ( ) Somnolent ( ) Unconscious ( ) GCS score E __ M __ V __

3. Ability to see ( ) Good sight of both eyes Right VA___ Left VA___ ( ) Loss of sight in one eye, which is side VA …...…..… side

( ) Loss of sight in both eyes Right VA___ Left VA___ ( ) Others …….....

4. Ability to use hand and arm

( ) Able to use two hands and two arms to perform activities of daily living

( ) Unable to use one hand and one arm to perform activities of daily living, please specify…….....

( ) Unable to use two hands and two arms to perform activities of daily living

( ) Others…….....

5. Ability to stand and walk

( ) Able to maintain balance and walk without assistance from others

( ) Unable to maintain balance and unable to stand up or walk by oneself

6. Mentality/behavior ( ) Like normal people ( ) Abnormal, please specify…….....……

7. Ability to perform occupation, both permanent and others

( ) Able to perform permanent occupation and other occupations

( ) Unable to perform permanent occupation and other occupations

b. Assessment result

1. Does the patient have a chance to be cured of the disability or not?

( ) Yes, because…….....

( ) Not conclusive, because…….....….

( ) No chance of being cured

2. Type of disability ( ) Temporary total disability ( ) Permanent partial disability ( ) Total and permanent disability

3. Current ability level is…….....

Level 1 Totally unable or with little ability to perform activities of daily living and require very much assistance

Level 2 Able to perform activities of daily living by oneself to a certain degree and require much assistance

Level 3 Able to perform activities of daily living by oneself a lot but may still need someone to help guide or look after or tools to aid disabled person or modification of personal belongings. However, the patient is not able to leave the house, continue with study, occupation, or join social gathering by oneself in spite of under an environment that supports disabled person.

Level 4 Able to perform activities of daily living by oneself with a use of tools to aid disabled person or modification of personal belongings. The patient is able to leave the house, continue with study or occupation, or join social gathering by oneself under an environment that supports disabled person.

Level 5 Able to perform activities of daily living by oneself with a use of tools to aid disabled person or modification of personal belongings. The patient is able to leave the house, continue with study or occupation, or join social gathering similarly to a normal person.

I hereby certify that the above statement is true in all aspects.

Sign……..……Attending physician

Medical license No. …… Medical center…….....

Date……..…… Month……..…… Year ……

(Affix with medical center seal)