

PRE-ADMISSION FORM FOR LOG

Please furnish the following information/documents to Ulink Assist Myanmar:

Incomplete information and medical documents may result in rejection or delay of LOG process.

PART (1) - TO BE COMPLETED BY INSURED OR POLICY OWNER

Section A: Patient Information

Name of Patient	
Policy Number	
NRC	
Admission date	
Hospital Name	
Doctor Name	

Section B: Contact details

Email	
Contact Number	

Section C: Declaration, Consent and Authorisation by Life insured or Policy owner

By completing the form, I hereby declare that:

- (a) I am the patient, or the patient's parent or guardian if the patient is under 18 years of age.
- (b) All information on this pre-admission form is true and correct based on the best of my knowledge.
- (c) I authorize my treating doctor(s), clinic, hospital or any other medical provider to provide access and furnish all necessary and relevant reports and/or medical and invoice information pertaining to my personal data and medical condition (these may include information regarding past medical history, psychological notes, drug or alcohol abuse notes, AIDS and other sexually transmitted disease related information) to Ulink Assist Myanmar and Daiichi Life Myanmar including their provider hospitals, as may be required.
- (d) I further authorise Ulink Assist Myanmar and Daiichi Life Myanmar including their provider hospitals to have access, to use, to receive and to share for valid purpose such reports and/or information

obtained from myself, authorised representatives, treating doctor(s), clinic, hospital or any other medical provider for the purpose of evaluating and providing my medical care, assistance services or healthcare benefits administration services, as well as to coordinate, assess and determine my entitlements, benefits and/or reimbursements in connection with my health or medical insurance coverage.

(e) I acknowledge that the information submitted herein shall be used only for the pre-authorisation of direct settlement by Ulink Assist Myanmar with the clinics/hospitals for any eligible and approved charges relating to my approved medical treatment. I agree to pay any excess amounts and uncovered medical expenses (if any) to clinics/hospitals or Ulink Assist Myanmar within 7 business days from date of request. The actual covered amount is subject approved based on the information provided in the pre-admission form, actual diagnosis, eligible policy benefit, exclusion clause, terms and conditions stated in the policy document.

(f) I have read and agreed to the following terms and conditions for LOG request.

- In the event that there is any complaint or dispute regarding the claim assessment, in the first instance please contact healthclaim@daiichilife.com.mm. Please ensure you provide us with all the relevant correspondence, documentation, evidence and situation details when you lodge your complaint. Your complaint will be thoroughly considered and investigated, and we will keep you informed of any appropriate development within 7 business days.
- Any case fees and exchange rate differences will be deducted from your annual policy limit each time Daiichi Life issuing the Final LOG, depending on the hospitalization expenses. If, after the hospital invoice is received, the actual exchange rate difference exceeds the amount deducted at the time the Final LOG was issued, the policy owner must pay the excess amount to DLMM within 14 working days.

Signature & Name (If on behalf of Life Insured)		Date of consent	
Name of Life Insured		Relationship with a patient (if applicable)	

PART (2) - TO BE COMPLETED BY ATTENDING DOCTOR

Section A: Medical details

a) Diagnosis / Provisional Diagnosis -

b) Are the condition and treatment related to the following:

- Pregnancy / Childbirth / Infertility / Miscarriage Or any complications arising therefrom
- Congenital / Hereditary disease
- Drugs / Alcohol abuse
- Mental / Psychiatric disorder
- Cosmetic reason / Dental care / Refractive errors correction
- STD / AIDS/ HIV related
- None of the above

c) Details of clinical features

Date of first consultation
Estimated date of onset of symptoms
Duration of symptoms
Description of signs and symptoms

d) Any previous consultation / treatment / hospitalization for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities prior to current admission?

YES NO

If YES, please send previous hospitalisation and medical reports.

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Doctor's Name		Doctor's Signature	
Medical License No. (or) Stamp of Doctor		Date of declaration	

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- Daiichi Life သည် customer များ စိတ်ချမ်းမြေ့ကျေနပ်မှု ရရှိစေရေးအတွက် အကောင်းဆုံးသော ဝန်ဆောင်မှုများ ပေးအပ်နိုင်ရန် အစဉ်အမြဲ ကြိုးစားလျက်ရှိပါသည်။ သို့ဖြစ်ပါ၍ customer များ ကျန်းမာရေး အကျိုးခံစားခွင့် တောင်းခံရာတွင် ပိုမိုလွယ်ကူလျင်မြန်စွာ ဆောင်ရွက်ပေးနိုင်ရန်အတွက် ယုံကြည်စိတ်ချအားကိုးရသော Ulink Assist Myanmar နှင့် တရားဝင်ပူးပေါင်း ဆောင်ရွက်မည် ဖြစ်ပါကြောင်း အသိပေးအပ်ပါသည်။
- စုံစမ်းမေးမြန်းလိုသည်များ ရှိပါက +95 9 774 777 733 သို့လည်း တိုက်ရိုက်ဆက်သွယ်မေးမြန်းနိုင်ပါသည်။

