

# The Process for Group Health Insurance Claim

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# How To Do?

If you are sick and go to see the doctor at the Private hospital

- Don't need to pay in advance
- Show the Muang Thai Health Care Group Insurance Card with your IDcard/ passport at the registration counter at the hospital.

Muang Thai Health Care Group Insurance Card -->



**Muang Thai HealthCARE** Group Insurance G-A16-0349-E0000000-00 โรงเรียน สาธิตนานาชาติ มหาวิทยาลัยมหิดล ระยะเวลาเอาประกัน : 01/04/2567 - 31/03/2568 ค่าท้อง-อาหาร/วัน 2,500 OPD/05 ค่ารักษาพยาบาลทั่วไป 40,000 ER Acc. (72 %N.) 12,000









# How To Do?

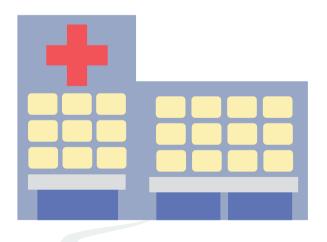
If you are sick and go to see the doctor at the Public Hospital

- > Pay in advance.
- > For reimbursement, please submit the required documents
- to HR as follows:
  - **1. Original Receipt**
  - 2. Original Medical Certificate
  - 3. Fill out the Group Health Insurance Claim Form











Muldol University International Demonstration School ( MULDS โรงเรียนสาธิดนานาชาติ มหาวิทยาลัยมหิดล

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1. Submit an original receipt

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|-----------------------|--|---|
|                       | ., *   | (91)  |
| Drug List             |  |   |
| vices - NonOffice HRS |  |   |
|                       |  |   |
| pecial Clinic         |  |   |
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|                       | รวมเงิน  |   |
| SCB Card #0021        | Total<br>รวมทั้งสิ้น                               |   |
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|                       | vices - NonOffice HRS<br>pecial Clinic<br>คลินิกพ์ | vices - NonOffice HRS<br>pecial Clinic<br>คลินิกพิเศษ<br>รวมเงิน<br>Total |

## าวิทยาลัยมหิดล ใบเสร็จรับเงิน 0-66-459279 1 6 6 4 6 10 7 7 7 1 9 **6** 1 1 1 1 Page: 1/1 จำนวนเงิน (บาท) าไม่ได้ เบิกได้ เขทรวงการคลัง) 1,352.00 50.00 50.00 500.00 550.00 1,402.00 1,952.00 WEE TUNPRAMWONG Cashier ด้ครบถ้วนแล้ว

FM-GJ-084 Rev.1 1 มันวาคม 2560

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Muldol University International Demonstration School ( Mulds โรงเรียนสาธิดนานาชาติ มหาวิทยาลัยมหิดล



Golden Jubilee Medical Center

Faculty of Medicine Siriraj Hospital Mahidol University 888 Village No.6, Salaya, Phuttamonthon, Makhon Pathom 73170 Thailand Tel. 0-2849-6600 Fax : 0-2-849-6666



|                    |                             |                                  | Date :                                |
|--------------------|-----------------------------|----------------------------------|---------------------------------------|
| Physic             | ian's NameN_MITHIITH        | CONVERTUILISIAM IAISIDE .        |                                       |
| Medical License No |                             |                                  |                                       |
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# 2. Submit a medical certificate



Doc No. : P-660911-027332

A16-0799



MC005 : DCC\_CON\_MC\_ENG.pt





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### Group Health Insurance Claim Form

💓 เมื่องไทยประกันชีวิต

I hereby express intention to claim medical expenses from Muang Thai Life Assurance Public Company Limited with the following information for consideration.

| Name of Policyholde                                    | er (Company Name): <mark>Mahidol I</mark>     | University Internation | onal D  | emonstration | Date  |
|--|---|------------------------|---------|--------------|-------|
| Group Policy No.:                                      | 00116862                                      | HealthCare Card No     | o.: G-A |              | -E    |
| Name – Surname of                                      | Patient:                                      |                        | Age:    | Years Old    | Gende |
| Present Address:                                       |   |                        |         |              |       |
| Contact Mobile Pho                                     | ne No.:                                       |                        |         | E-mail:      |       |
| Type of Treatment: DInpatient (IPD): Date of Admission |   |                        |         |              |       |
|  | 🗹 Outpatient (OPD) 🛛 Dental Date of Treatment |                        |         |              |       |
|  | Others (Please specify)                       |                        | Date    | of Treatment |       |
| Cause: 🗆 Illness 🗆 Accident Date of AccidentTime       |   |                        |         |              |       |
| Descriptions of Incident:                              |   |                        |         |              |       |
|  |   |                        |         |              |       |

Are you eligible for compensation from other companies? 
Yes, please specify

### Declaration and Authorization of Medical History Disclosure

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

### Declaration of Personal Data Disclosure

I give consent to the Company to collect and use Personal Data, health information, disability, religion, race, medical record, and claim record of me and/or the person under my guardianship (as the case may be), both provided above at present and in the future (collectively referred to as "Sensitive Data"). This consent also includes disclosure of such Sensitive Data as necessary to executives, employees and life insurance agents of the Company, life insurance brokers, banks, reinsurance companies, other insurance companies, medical centers, group insurance policyholders, the Thai Life Assurance Association (TLAA), units with duty to collect/pay policy benefits, government agencies, agencies and commissions which are responsible for law enforcement or legally registered, state agencies or regulators, the Company's business partners, foundations, and the Company's vendors or services providers, to allow the Company, persons and agencies to collect and use the Sensitive Data as necessary and required by law for the purposes of insurance application, underwriting, policy benefit payment, medical treatment, and as a central database of insurance companies in order to examine insured's history and claim record, any operations regarding insurance policies, future insurance application and for any purposes which benefit the insured.

I acknowledge that by not giving consent and by changing the scope of consent, withdrawing consent, objecting, requesting for erasure or destruction of Personal Information, it may result in the Company being unable to manage or take any necessary action on the insurance contract and may affect services and policy benefit payment. In this regard, I have already acknowledged the Company's Privacy Policy on www.muangthai.co.th/th/privacy-policy. In this regard, the expression of my intention by marking 🗸 In 🗆 constitutes that I have given explicit consent to collect, use and disclose the Personal Data according to the purposes specified above. Hereby, I have signed as evidence thereof. I have explicitly acknowledged the statements above and the Company's Privacy Policy and hereby signed to authorize and give consent to the disclosure of medical history above.

| Sign  | Sign)<br>(                                 | Sign(    |
|---|--|----------|
|   |  |          |
| * Sign Consent grante   | or Relationship                            |          |
| ( )   |  |          |
| Remarks:         1. In case of signing by fingerprint, signatures of 2 witnesses           *2. In case of a minor (not over 10 years old), a parent is requ           *3. In case of a minor (over 10 years old but less than 20 year minor and specify the relationship. | ired to sign and specify the relationship. | Scan for |

3. Complete the Group **Health Insurance Claim** Form

Group PDPA EN start 23052565

### Wisdom of the Land



For Group Insured Member Only

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Witness



details of Privacy Policy



Mahidol University International Demonstration School ไรงเรียนสาธิดนานาชาติ มหาวิทยาลัยมหิดล



# The process for HR about Group Health Insurance Claim

Reference for MUIDS Human Resource Management in Group 6, The school provided Group Health Insurance for employees

