TO : TAIJU LIFE INSURANCE COMPANY LIMITED

Outpatient Visits Certificate

English only : Please type or write in block letters

Name		Sex : Male / Female	Date of Birth (Month / Day / Year)	______ / ______ /______ Age : ( )
Clinical diagnosis			Hospitalization : *(Month / Day / Year) From : ______ / ______ / ______ To : ______ / ______ / ______	
In case of accidents, please fill the right column.			The accident occurred on (Month / Day / Year) ______ / ______ / ______	

Please circle the dates requiring outpatient visits on the calendar below. These outpatient visits are limited to the treatment related to the Hospitalization * , and which might occur within 120 days after the discharge.

(Month / Year)		Total Sum
______ / ______	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	days
______ / ______	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	days
______ / ______	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	days
______ / ______	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	days
______ / ______	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	days

These statements are true to the best of my knowledge and belief

Name of hospital : ______________________________

Address of hospital : ______________________ Country : ______________

Signature : ______________________ Date : ______________