



CLAIMANT STATEMENT

Hospitalization / Medical Reimbursement Claim

Kindly take note of the following reminders in filling out this form:

1. This form is used only for **HOSPITALIZATION** Claims or **MEDICAL REIMBURSEMENT** Claims.
2. We are requesting the Claimant to please accomplish all questions in **FULL** and in **PRINT**.
3. Please attach **ORIGINAL FINAL BILLS** and **RECEIPTS** only.

Insured or Covered Member Information

1.	(a) Full Name of INSURED/COVERED MEMBER			(b) Date of Birth		
	First	Middle	Last	mm	dd	yyyy
2.	Address	House No./Street/Bldg				
		Subdivision/Brgy/District				
		Town/City/Province				
3.	Occupation				Sex	
4.	Policy numbers to which you are claiming for Hospitalization and/or Medical Reimbursement					
	Policy Number/s	Policy Number/s	Policy Number/s	Policy Number/s	Policy Number/s	

Please complete this section if claim is due to SICKNESS

5.	Describe the Nature of Ailment.							
6.	(a) When did the symptoms of the illness begin?	mm	dd	yyyy	(b) Date of first visit to your doctor.	mm	dd	yyyy
7.	Names and addresses of all doctors or hospitals who/where you sought previous treatment							
	Name	Address	Dates Attended	Disease or Condition				
8.	Name and Address of your Family Doctor or Regular Doctor, other than the above	Name:						
		Address:						
9.	Have you undergone any surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
		If yes, state the type of the surgery (you may consult your doctor for the exact name of the surgery)						
		Type of Surgery:						
		When:						
Where:								
10.	What other insurance companies are you insured with?							
	Company Name	Effective Date	Amount of Insurance					

Please complete this section if claim is due to ACCIDENT						
11.	(a) Date Of Accident	mm	dd	yyyy	(b) Time of Accident :	<input type="checkbox"/> AM <input type="checkbox"/> PM
12.	Place of Accident	House No./Street/Bldg				
		Subdivision/Brgy/District				
		Town/City/Province				
13.	Nature of Accident (you must submit a copy of the Police Report. If not available, submit a written narration of the accident)	<input type="checkbox"/> Road Traffic Accident	<input type="checkbox"/> Accidents caused by Machinery			
		<input type="checkbox"/> Hit by a Heavy Object/Person	<input type="checkbox"/> Pricked by a Sharp Object			
		<input type="checkbox"/> Fire, Explosion, Hot Substance	<input type="checkbox"/> Accidental Fall			
		<input type="checkbox"/> Attacked/Bitten by Insect/Animal	<input type="checkbox"/> Cut by Substance/Device			
		<input type="checkbox"/> Natural Disaster / Environmental				
		<input type="checkbox"/> Others	Please Specify: _____			
14.	Describe briefly but accurately how the accident happened.					
15.	Give the Name and Address of a witness to the accident	Name:				
		Address:				
16.	Names and addresses of all doctors or hospitals who/where you sought previous treatment					
	Name	Address		Treatment dates	Disease or Condition	

Claimant Information (To be filled up only if the Insured/Covered Member is different from the Claimant)				
17.	(a) Full Name of CLAIMANT	First	Middle	Last
18.	Address	House No./Street/Bldg		
		Subdivision/Brgy/District		
		Town/City/Province		

Authorization and Declaration	
19.	Is the agent on record (the agent appearing in the insurance application form) authorized to pick-up your claim check? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, a duly written authorization is required, and only to the agent on record

I HEREBY CERTIFY that the foregoing answers are true and correct to the best of my knowledge and **HEREBY AUTHORIZE** all doctors or other persons who treated me and all hospitals or other institutions to furnish full information (including full copies of their records) regarding this claim.

It is understood that any action you may take in connection with this authorization, releases you or any members of your staff from any responsibility or obligation in connection with the release of such records or information. I agree and authorize that a photocopy of this authorization shall be considered as effective and valid as the original.

I further agree that the furnishing of this form, or of any other forms supplement thereto, by THE PHILIPPINE AMERICAN LIFE AND GENERAL INSURANCE COMPANY shall not constitute nor be considered an admission that there was any insurance in force on the life of the Insured, nor any waiver of any of its rights to defense.

20.	Claimant Signature Over Printed Name	Date of Signing
		Place of Signing
Cellphone Number (where we will send status & updates of your claim)		