PHILAM LIFE

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 First / Middle / Last				(b) Date of Birth 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		

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?	☐ Yes ☐ 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 :	☐ AM ☐ 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)	☐ Road Traffic Accident ☐ Hit by a Heavy Object/Person ☐ Fire, Explosion, Hot Substance ☐ Attacked/Bitten by Insect/Animal ☐ Natural Disaster / Environmental ☐ Others Please Specify: _____ ☐ Accidents caused by Machinery ☐ Pricked by a Sharp Object ☐ Accidental Fall ☐ Cut by Substance/Device
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?	☐ Yes ☐ 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.		Date of Signing
	Claimant Signature Over Printed Name	Place of Signing
	Cellphone Number (where we will send status & updates of your claim)	