

Accident / Sickness Insurance Claim Form



This form must be completed truthfully and accurately
 The list of documents required is not exhaustive and we reserve our right to request from you any additional information / documentation, as necessary. The submission of an incomplete form or insufficient information or supporting documents may delay the processing or result in the denial of your claim.
 The completed form should be returned to us together with all supporting documents as soon as possible at the following address:

Claims Department

AIG Philippines Insurance, Inc. (formerly known as Chartis Philippines Insurance, Inc.)

30th Floor, Philam Life Tower 8767 Paseo De Roxas Street 1226 Makati City, Philippines

Filing by the assured / claimant of this claim form is for purposes of claim evaluation only and does not constitute admission of liability by AIG Philippines Insurance Inc. (formerly known as Chartis Philippines Insurance, Inc.) We reserve the right for additional document(s), if need be.

GENERAL REQUIREMENTS

Basic documents required

- Duly accomplished and signed accident/sickness insurance claim form;
- Copy of certificate of insurance
- Proof of premium payment
- Photocopy of valid ID

Additional required documents for

Accident Death Claim: (Original or Certified True Copies of)

- Attending physician's report
- Police investigation report of statement of witness(es);
- Birth Certificate
- Death Certificate
- Autopsy Report
- Marriage Contract

Accident / Sickness Hospitalization / Dismemberment claim:

- Attending physician's report
- Police investigation report of statement of witness(es);
- Hospital statement of account
- Original copy of medical bills and receipts
- Prescriptions
- Medical records (history / diagnosis)

GENERAL INFORMATION ON ASSURED				
NAME OF ASSURED	<table border="1"> <tr> <td style="width: 33%; text-align: center;">Last Name</td> <td style="width: 33%; text-align: center;">First Name</td> <td style="width: 33%; text-align: center;">Middle Name</td> </tr> </table>	Last Name	First Name	Middle Name
Last Name	First Name	Middle Name		
Type of Policy / Policy No.				
GENERAL INFORMATION ON CLAIMANT				
CLAIMANT'S NAME	<table border="1"> <tr> <td style="width: 33%; text-align: center;">Last Name</td> <td style="width: 33%; text-align: center;">First Name</td> <td style="width: 33%; text-align: center;">Middle Name</td> </tr> </table>	Last Name	First Name	Middle Name
Last Name	First Name	Middle Name		
Nationality				
Social Security No. (for U.S. Citizen)				
CLAIMANT DATE OF BIRTH	(mm/dd/yyyy) / /			
RELATIONSHIP TO ASSURED				
GENDER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
AIG Employee?	<input type="checkbox"/> YES <input type="checkbox"/> NO			
RESIDENCE ADDRESS				
Street				
Province / City				
Zip Code				
Telephone No.				
Fax No.				
E-MAIL ADDRESS				
BUSINESS ADDRESS				
Street				
Province / City				
Zip Code				
Telephone No.				
Fax No.				
E-MAIL ADDRESS				

DETAILS OF ACCIDENT / ILLNESS / INJURY	
DATE	(mm/dd/yyyy) / /
PLACE	
NATURE OF ACCIDENT / ILLNESS / INJURY	
DESCRIPTION OF ACCIDENT / ILLNESS / INJURY – HOW DID IT OCCUR?	
PLACE(S) CONFINED	FROM (mm/dd/yyyy) / / TO / /
HOUSE	FROM (mm/dd/yyyy) / / TO / /
HOSPITAL	
ATTENDING PHYSICIAN(S) NAME(S)	
ADDRESS(ES)/TEL. NO.:	
DO YOU HAVE ACCIDENT OR SICKNESS INSURANCE WITH ANY OTHER COMPANY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, NAME OF CO-INSURER	

