Accident / Sickness Insurance Claim Form

47th Floor PBCom Tower,Ayala Avenue,
Makati City 1229
P.O. Box 2238, Makati, Philippines
Tel. No. 817-3000 / Fax No. 878- 5450

CLAIM FORM

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. We reserve the right to request for additional document(s), if need be.

GENERAL REQUIREMENTS

Basic documents required: 1) Duly accomplished and signed accident / sickness insurance claim form; 2) Copy of certificate of insurance; 3) Proof of premium payment

Additional required documents for

Accident Death Claim: 1) Attending physician's report; 2) Police investigation report or statement of witness(es); 3) Birth certificate; 4) Death certificate; 5) Autopsy report; 6) Marriage contract

Accident / Sickness Hospitalization / Dismemberment Claim: 1) Attending physician's report; 2) Police investigation report or statement of witness(es); 3) Hospital statement of account; 4) Original copy of medical bills and receipts; 5) Prescriptions; 6) Medical records (history / diagnosis)

GENERAL INFORMATION ON ASSURED

NAME OF ASSURED _____ _____ _____
Last Name *First Name* *Middle Initial*

POLICY NO. _____ AIG Employee? ☐ Yes ☐ No

GENERAL INFORMATION ON CLAIMANT

CLAIMANT'S NAME _____ _____ _____
Last Name *First Name* *Middle Initial*

RESIDENCE ADDRESS
Street _____
_____
Province / City _____ Zip Code _____
TELEPHONE NO. _____ FAX NO. _____
E-MAIL ADDRESS _____
CLAIMANT DATE OF BIRTH *(MM/DD/YYYY)* _____

BUSINESS ADDRESS
Street _____
_____
Province / City _____ Zip Code _____
TELEPHONE NO. _____ FAX NO. _____
E-MAIL ADDRESS _____
RELATIONSHIP TO ASSURED _____

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

☐ HOUSE FROM *(MM/DD/YYYY)* _____
TO *(MM/DD/YYYY)* _____

☐ HOSPITAL FROM *(MM/DD/YYYY)* _____
TO *(MM/DD/YYYY)* _____
NAME _____
ADDRESS _____

ATTENDING PHYSICIAN(S)
NAME(S) _____ ADDRESS(ES) _____
_____ _____
_____ _____

DO YOU HAVE ACCIDENT OR SICKNESS INSURANCE WITH ANY OTHER COMPANY? ☐ Yes ☐ No
If YES, NAME OF CO-INSURER _____ POLICY NO. _____

I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective as the original.

IN WITNESS THEREOF, I have hereunto signed this Claim Form this _____ day of _____ at the City of _____, Philippines.

_____
PRINTED NAME AND SIGNATURE OF ASSURED

REPUBLIC OF THE PHILIPPINES)
_____) S.S.

SUBSCRIBED AND SWORN to before me this _____ day of _____ at _____, Assured having exhibited to me his / her Community Tax Certificate No. _____, issued on _____ at _____.

DOC NO. _____
PAGE NO. _____
BOOK NO. _____
SERIES OF _____

_____
NOTARY PUBLIC

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Attending Physician's Report

NAME OF PATIENT _____ _____ _____
Last Name *First Name* *Middle Initial*

SEX *(M/F)* _____ AGE _____

NATURE OF ILLNESS / INJURY

CHIEF COMPLAINT _____
FINAL DIAGNOSIS _____
BRIEF HISTORY OF _____
PRESENT ILLNESS _____
COMPLICATIONS, IF ANY _____

IS CONDITION DUE TO:

FRACTURE / DISLOCATION? ☐ Yes ☐ No
If YES,
Nature of fracture / dislocation is ☐ Complete ☐ Incomplete

LOSS OF SIGHT? ☐ Yes ☐ No
If YES,
Loss of sight is in ☐ Left eye ☐ Right eye ☐ Both eyes
Nature of sight loss is ☐ Entire & irrecoverable ☐ Partial & recoverable
Date of first appearance of symptoms / accident *(MM/DD/YYYY)* _____

PREGNANCY? ☐ Yes ☐ No
If YES,
Date of first consultation *(MM/DD/YYYY)* _____

INJURY OR SICKNESS OUT OF PATIENT'S EMPLOYMENT? ☐ Yes ☐ No

FULLY DESCRIBE NATURE OF SURGICAL OR OBSTETRICAL PROCEDURES, IF ANY _____

PATIENT HOSPITALIZED? ☐ Yes ☐ No
HOSPITAL _____
ADDRESS _____
DATE ADMITTED *(MM/DD/YYYY)* _____
DATE DISCHARGED *(MM/DD/YYYY)* _____

LAB EXAM RESULTS _____

MEDICATIONS GIVEN _____

_____
PRINTED NAME & SIGNATURE OF ATTENDING PHYSICIAN

ADDRESS _____
LICENSE NO. _____
P.T.R. NO. _____
ISSUED AT _____
ON *(MM/DD/YYYY)* _____
TIN _____

Consent for Claimants

By providing your Personal Information to AIG Philippines in connection with your claim and by signing below, you consent to the collection and processing (including the use and disclosure) of your Personal Information as described in this Privacy Policy available at www. Aig.com.ph or upon request. In particular you consent to the transfer of your Personal Information internationally. You agree that you will not provide Personal Information about any other individual without that person's permission.

[Signature: _____
Name: _____
Date: _____**]**