PHILAM LIFE
An AIA Group Company

HELPING PEOPLE LIVE
HEALTHIER, LONGER, BETTER LIVES

Disability / Critical Illness / Medical Reimbursement / Hospitalization Claim

We understand that this claim is important to you. In order for us to speed up the process, please: (1) complete this form, (2) prepare the required documents; and, (3) submit the completed form and required documents to your agent or Philam Life Branch.

Being prepared might reduce some of the confusion and could help speed up the process. We want your claim experience to be a positive one.

To ease your claim procedures, use this checklist to identify the relevant documents required to be submitted.

Additional requirements may be required if the claim falls within the two-year contestability period of the policy.

MANDATORY REQUIREMENT/s

☐ **For Waiver of Premium, Dismemberment, Disability and Critical Illness**

- ☐ Claimant Statement Form - duly accomplished and signed by the claimant(s)
- ☐ Valid ID of the Claimant(s) – present the actual ID(s) and submit photocopy (ies)
- ☐ Complete Medical Records – include copy of actual admitting history, discharge summary and all laboratory or work up results. in-patient or out-patient consultation from clinics and hospitals should include Operation technique/Operation report if amputation or disarticulation was performed and claiming for accident or disability or waiver of premium
- ☐ Attending Physician Statement Form (Critical illness or Disability) - duly accomplished and signed by the Attending Physician

☐ **For Medical Reimbursement and Hospital Confinement Benefit**

- ☐ Claimant Statement Form - duly accomplished and signed by the claimant(s)
- ☐ Valid ID of the Claimant(s) – present the actual ID(s) and submit photocopy (ies)
- ☐ Original or Certified True Copy of the Statement of Account (SOA) - in the absence of the SOA, you may submit a Hospital Certification signed by an authorized personnel from the billing or Records Section of the hospital when claiming for Hospital Claim (Medical Expense Benefit)
- ☐ Attending Physician Statement Form (Hospitalization or Medical Reimbursement) – duly accomplished and signed by the Attending Physician
- ☐ Medical Receipts – if Medical Reimbursement
- ☐ Police or Incident Report – if due to an accident
- ☐ For Surgical Cases – Certified True Copy of the Operating Room Record

Warning: filing of fraudulent claim is penalized by law:

Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.

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Date: (mm/dd/yyyy) _____

Policy Number

Indicate policy numbers where this claim may also be applicable

Certificate Number
(Applicable for Corp.Sol. only)

_____, _____, _____

This form is to be filled by the claimant. Please do not sign a blank form. No fees, commission or charges of whatever nature are payable to Agents or Employees of the Company in respect of this claim.

GENERAL INFORMATION

Name of Insured/Owner who is suffering from disability:
(Last Name, First Name, Middle Name)

Date of Birth: (mm/dd/yyyy)

Current Occupation: (Please state exact nature)

TYPE OF CLAIM/S

☐ Hospital Confinement Benefit ☐ Waiver of Premium ☐ Disability

☐ Medical Reimbursement ☐ Dismemberment ☐ Critical Illness

Glossary / Definition:

- Dismemberment – loss of a body part or the function of certain body parts
- Waiver of Premium – waives the policy holder's obligation to pay any further premiums should he become seriously ill or disabled
- Medical Reimbursement – a method of payment for medical treatment or hospital costs
- Hospital Confinement Benefit – provides daily cash benefit while the insured stays in a hospital
- Critical Illness – a life-threatening condition, which is generally and strictly defined
- Disability - refers to inability or decreased ability of performing the usual duties of one's occupation or activities of daily living due to sickness or accident)

Send me Policy updates via: ☐ Email ☐ Mail ☐ SMS Notification

Mobile Number: (09XX - XXXXXXX)

Email:

Home Address:

TIN:

☐ I am a US Citizen or US Tax Resident with TIN _____

Track your Claim Status

Once your claim is registered, you will be updated through SMS. If you have any query on your claim, please reach us at:

TALK TO US NOW
(02) 528-2000

EMAIL US
PHILAMLIFE@AIA.COM

Philam Life is committed to making your customer experience as easy and stress-free as possible. Thank you for insuring with us. We are always glad to be of service.

Philam Life Head Office
15-18th F Net Lima Bldg.
5th Avenue corner 26th St.
Bonifacio Global City,
Taguig, Metro Manila,
Philippines 1634

IF THIS CLAIM IS DUE TO DISABILITY, PLEASE COMPLETE THIS SECTION

What particular disability is the Insured/owner suffering from?

Please share below the Activities of Daily Living (ADL) that the Insured/Owner is currently UNABLE to perform without assistance:

- ☐ Ability to feed oneself
- ☐ Ability to attend to own toilet needs
- ☐ Ability to wash and bathe oneself
- ☐ Ability to dress
- ☐ Ability to get in and out of bed
- ☐ Ability to move from room to room on level surface

IF THIS CLAIM IS DUE TO ILLNESS, PLEASE COMPLETE THIS SECTION

Date illness was first diagnosed:

Chief complaints for consultation:

Date symptoms discovered/felt:

Date of first consultation:

IF THIS CLAIM IS DUE TO ACCIDENT, PLEASE COMPLETE THIS SECTION

Details of injury (ies) Sustained:

Date & Time of Accident:

Place of Accident:

PAYMENT INSTRUCTION: (all succeeding benefits will be credited to the indicated Bank Account)

☐ Credit to my Bank Account
(NOTE: If the account you specify is with a bank other than BPI or BDO, applicable charges may be deducted from the proceeds)

Bank: _____ Branch: _____

Type of Account: ☐ Savings ☐ Checking Account Currency: ☐ Dollar ☐ Peso

Account Name: _____

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐

☐ Claim at any BPI / BPI Family Branch
(NOTE: In this option, you are authorizing the Company to use the mobile phone number stated above for communication pertaining to the transaction)

I certify that I am the owner/insured/beneficiary/assignee of the policy (ies) with Philam Life and that I am the account owner of the above designated bank account. I certify to the accuracy and truthfulness of the bank information which I provided and I am aware that any discrepancy may cause delay in the crediting of the proceeds to my account. In the event of changes to this information, I shall inform Philam Life in writing. Further, I agree that the crediting by Philam Life of the amount that may be due to me to the above bank account which I designated shall forever release and discharge Philam Life from all actions, claims, and demands relating to my claim against the policy (ies) with Philam Life.

Claimant's Signature	Date	Place

DECLARATIONS AND AUTHORIZATIONS:

1. I hereby certify that all information, including all of my personally identifiable and sensitive information, which I have voluntarily provided to The Philippine American life and General Insurance Company, through this Form and related documents is true and correct to the best of my own knowledge and belief;
2. I further agree to third party processors required by the Company in order to maintain quality and deliver efficient and effective services relevant to my claim and other services I have availed of.
3. In compliance with the Data Privacy Act (DPA) of 2012, and its Implementing Rules and Regulations (IRR) effective since September 8, 2016, I allow the Philippine American Life and General Insurance Company (Philam Life) to provide me certain services declared in relation to the insurance policy/ies I purchased. As such, I agree and authorize PhilamLife Company to;

    a. Continue to use my and my policies' information to process insurance services and administer the benefit as stated in my policy(ies).

    b. Retain my information for a period of 7 years from the date of termination of my policy, or at such time that I submit to Philam Life a written cancellation of this consent, whichever is earlier. I agree that my information will be deleted/destroyed after this period.

    c. Retain my information in the Medical Information Database shared with other life insurance companies in accordance with the Insurance Regulation.

    d. Share my information to affiliates and necessary third parties for any legitimate business purpose. I am assured that security systems are employed to protect my information.

4. I hereby acknowledge and warrant that I have acquired the consent of all parties pertinent to this transaction to disclose their information for the proper administration and provision of services requested from this transaction. I hereby hold free and harmless and undertake to indemnify the Company for any complaint, suit or damages and the like which any party may file or claim against the Company in relation to this Acknowledgement and warranty.
5. I hereby authorize Philam Life or any of its authorized representative to secure whatever information or records from any employer, physician, hospital or clinic, other medically related facility, and any organization or persons who have records and/or knowledge with regards to the illness, sickness or injury of the Insured as described in this Claim Statement Form. This authorization is in connection with my claim on the insurance policy (ies) issued by the Company on the life of the insured. I understand that failure to release such employment or medical records may delay the processing and/or deny my claim for insurance proceeds.

Claimant's Name in Full:
(Last Name, First Name, Middle Name)

Claimant's Signature | Date | Place