The Insular Life Assurance Company, Ltd.
Insular Life Corporate Centre, Insular Life Drive Corporate
Filinvest Corporate City, Alabang, 1781 Muntinlupa City
E-mail: headofc@insular.com.ph • Website:
www.insularlife.com.ph Tel.: (632) 582-1818 • Fax: (632) 771-1717
• TIN 000-464-124 Non-VAT

Hospitalization Claim Form

INSTRUCTIONS: (1) This hospitalization claim is to be accomplished in full (all questions answered and signed) by the following: INSURED (Part I); Authorized Representative of the hospital (Part II); and, Attending PHYSICIAN (Part III). (2) In case of hospital confinement due to accident, the following items should also be submitted: (2.1) copy of the police report and/or (2.2) sworn statement of at least an eyewitness. (3) Submit the accomplished hospitalization claim form together with the item specified above to 18TH Floor, Customer Care Unit, , The Insular Life Assurance, Co., Ltd., Insular Life Corporate Centre, Insular Life Drive, Filinvest Corporate City, Alabang, 1781 Muntinlupa.

PART I: INSURED'S STATEMENT

Given Name: Surname: Suffix:	Address:	Tel. No.:
Policy No: _____ Effective Date: _____	Date of Birth: _____ Occupation: _____	Age: _____ Sex: _____
Name of Hospital:	Address:	Tel. No.:
For confinement due to sickness: Date first symptoms discovered: _____ Date of first Examination/treatment: _____ Name/s and address/es of all physicians who attended you _____ _____ _____ _____	For confinement due to accident: Date and time of accident: Month:____ Day: ____Year: ____Time:____ Place of accident: _____ Describe fully the nature of ailment/injury sustained: _____ _____ _____	

WARNING: It is unlawful (a) to present or cause to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and (b) to fraudulently prepare, make or subscribe any writing with intent to present or use the same, or to allow it to be presented in support of any claim. Such acts shall be punishable by a fine not exceeding twice the amount claimed or imprisonment of two (2) years, or both, at the discretion of the court. (Section 251, Insurance Code).

I hereby certify that to the best of my knowledge and belief, the foregoing and accompanying statements are complete and accurate. I understand that the furnishing of this form and other claim forms by the Company does not constitute an admission that there is any insurance in force. I authorized any physician or other person, hospital, clinic, other medically related facility or institution and any eyewitnesses to furnish the INSULAR LIFE Assurance Company Ltd., or its duly authorized representative with any and all information concerning my hospital confinement, including, my medical history. This information is to be used in connection with my proof of loss under my Insurance Policy. I agree that photocopy of this authorization shall be considered valid.

_____ _____
SIGNATURE DATE

PART II: HOSPITAL'S AUTHORIZED REPRESENTATIVE'S STATEMENT

Name of Patient:		
Date of Birth:	Age:	Sex:
Diagnosis/Nature of Illness/Injury:		
Hospital Confinement recommended or sought by:		
Date Admitted:	Time Admitted:	
Date Discharged:	Time Discharged:	
Name of Hospital:		
Address:		Tel. No.:
Registration/Permit No.:	Date Issued:	Issued By:

I hereby certify that the foregoing statement is, to my knowledge and belief, complete and accurate:

SIGNATURE: Date:

Name of Representative:

Official Title:

NOTICE TO HOSPITAL: Attach the patient's hospital chart or clinical chart record and the Statement of Account signed by your authorized officer together with all other bills and/or receipts covering hospital charges incurred during confinement.

PART III: ATTENDING PHYSICIAN STATEMENT

Name of Patient:

Period of Hospital Confinement:

From: To:

Complete Diagnosis/Prognosis:

Have you advised patient of your finding? If not, Why?

Medical Treatment Given:

Is any surgical operation, contemplated or has been performed? If so,

What? _____

When? _____

Where? _____

By Whom? _____

Have you previously attended him? If so,

WHEN?	FOR WHAT?

When, in your opinion, can he resume his usual occupation or employment?

I hereby certify that the foregoing statements are true, complete & correct according to my knowledge and belief.

SIGNATURE: Date:

Name of Physician:

PTR No.: Tel. No.: