The Insular Life Assurance Company, Ltd.
Insular Life Corporate Centre, Insular Life Drive
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

I-Heal

INSTRUCTIONS TO CLAIMANT:

1. This form (I-Heal Claim Form II) must be completed by the AUTHORIZED OFFICER of the hospital. (If not applicable, please write N/A in the space provided for.)

2. The following must be submitted, along with this form:
   2.1. Hospital's Statement of Account and Receipt of Payment;
   2.2. Insured's Hospital records such as Admitting History, Clinical History and Physical Examination, Discharge Clinical Summary, Results of any Medical Examinations/Laboratory Tests, or their equivalent;
   2.3. Insured's Statement of Claim (I-Heal - Accident or Sickness Form I, as applicable);
   2.4. Physician's Statement (I-Heal Claim – Accident or Sickness Form III, as applicable);
   2.5. Surgeon's Certification (I-Heal Claim form IV), if surgery was performed; and
   2.6. All required documents indicated in the above-listed forms.

3. Submit to the Customer Care Unit of The Insular Life Assurance Company, Ltd. located at the above address or to any Insular Life Office.

HOSPITAL'S CERTIFICATION
(I-HEAL CLAIM FORM II)

Name of Patient: _____
Surname | Given Name | Suffix (Sr., Jr., etc.)

Date of Birth:	Age:	Gender:	Marital Status

Complete Name/s of Attending Physician/s:

Dates of Confinement:
Admitted on _____ (Month) (Day) (Year) Time: _____ Discharged on : _____ (Month) (Day) (Year) Time: _____

TO BE COMPLETED BY THE HOSPITAL'S AUTHORIZED REPRESENTATIVE
ONLY IF THE HOSPITAL STATEMENT OF ACCOUNT CANNOT PROVIDE THE DATA HEREIN.

Room & Board:
Regular Rooms: _____ days
From ___/___/___ (Month) (Day) (Year) To ___/___/___ (Month) (Day) (Year)
ICU : _____ days
From ___/___/___ (Month) (Day) (Year) To ___/___/___ (Month) (Day) (Year)

Other Hospital Charges:
Operating Room ..... P_____
Anesthesia ..... P_____
Laboratory ..... P_____
EKG, BMR, etc. ..... P_____
X-Ray ..... P_____
Drugs, medicines, etc. ..... P_____
Dressings ..... P_____
Oxygen/blood transfusions ..... P_____
Diathermy, Physical Therapy, etc. ..... P_____
Others ..... P_____
TOTAL P_____

Has this bill been paid? ☐ Yes ☐ No If yes, attach Official Receipt.

Name of Hospital:

Address of Hospital: _____
No. | Name of Street/ Highway | Town/Municipality | City/Province | Country | Zip Code

Contact Nos.:	Email address:

Bureau of Health Facilities and Services, DOH Registration/Permit No. _____

Date Issued: _____ Issued By: _____

I HEREBY CERTIFY that the foregoing answers have been taken from the hospital records of the above-named patient. They are true, correct and complete.

_____
Printed Name & Signature of Hospital's Authorized Representative

Official Title: _____

Date Signed: _____