



## I-Heal

### INSTRUCTIONS TO CLAIMANT:

1. This form (I-Heal Claim Accident Form I) is to be used if disability is due to an accident and must be completed by the INSURED/POLICYHOLDER. (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 Certification (I-Heal Claim Form II);
  - 2.2. Physician's Statement (I-Heal Claim – Accident Form III);
  - 2.3. Surgeon's Certification (I-Heal Claim Form IV), if surgery was performed;
  - 2.4. All required documents indicated in the above-listed forms;
  - 2.5. Copy of the Police Report;
  - 2.6. Sworn Statement of Witness/es, if any;
  - 2.7. Newspaper Clippings, if any; and,
  - 2.8. All applicable documents indicated under Items 6 & 7 below.
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.

**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.)

### INSURED'S STATEMENT OF CLAIM (I-HEAL CLAIM ACCIDENT FORM I)

To: The Insular Life Assurance Company, Ltd.

I hereby submit this claim under the policy or policies of this Company, numbered as follows: \_\_\_\_\_  
All of the following answers and statements are true, complete, and correctly recorded.

I understand that:

- 1) Issuance of this form and other claim forms by the Company does not constitute an admission that there is any insurance in force.
- 2) Insular Life shall evaluate the reasonableness of amount of charges and expenses claimed and shall process the claim in accordance with the customary medical expenses and professional fees for the type of disability that I am filing, subject to the applicable policy contract provisions.

### OTHER POLICIES OF INSURED WITH US OR WITH OTHER INSURANCE COMPANIES:

Policy Number	Name of Insurance Company	Amount of Insurance

### INFORMATION ON THE INSURED

Given Name: _____		Surname: _____		Suffix: _____	
<b>Mother's Maiden Name</b>					
Given Name: _____		Surname: _____			
Date of Birth: _____			Place of Birth: _____		
Occupation: _____		Gender: _____	Marital Status: _____		
Present Address:					
House No.		Street		Barangay	Town/Municipality
City/Province			Country		Zip Code
Residence Tel No.		Office Tel. No.	Mobile No.		Email Address

### INFORMATION ON THE POLICYHOLDER (if Insured is different from Policyholder)

Given Name: _____		Surname: _____		Suffix: _____	
Date of Birth: _____			Gender: _____		
<b>Mother's Maiden Name</b>					
Given Name: _____		Surname: _____			

**INFORMATION ON THE ACCIDENT**

1. Date and time of accident \_\_\_\_\_  
 \_\_\_\_\_  
 Month Day Year Time

2. Place of accident: \_\_\_\_\_  
 Name of Street/ Highway City or Municipality Province Country

3. Narrate completely how the injury was sustained: (Please use back page of this form if you need more space.)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. Where were you before the accident? What were you doing before the accident happened? Who were with you before the accident?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. If you are employed, were you at work at time of accident? If yes, give details:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. Please answer if claim is due to a vehicular accident  
 6.1. During the accident, were you a passenger, driver or pedestrian? \_\_\_\_\_  
 6.2. If driving or riding a motorcycle, were you wearing a helmet? YES \_\_\_\_\_ NO \_\_\_\_\_  
 6.3. If driving or riding a vehicle, were you wearing a seatbelt? YES \_\_\_\_\_ NO \_\_\_\_\_  
 6.4. Please fill up the following:

If traveling by land	
Route:	
Name of Driver :	
Vehicle type:	
Plate number:	
Registration year:	
Please attach photocopies of Official Receipt, Certificate of Registration and your Driver's License, if you are the one driving.	

If traveling by plane or ship	
Name of Airline/Shipping Company	
Office Address of Airline/Shipping Company:	
Telephone Nos.	E-mail address
Please attach a Certification from the Airline/Shipping Company stating that you are included in the list of passengers manifest.	

7. Was a police investigation conducted on the accident? If yes, please submit certified true copy of the police investigation report and copy(ies) of statement(s) of witness(es). If "No", explain why such investigation was not made.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

8. Names and addresses of witnesses to the accident:

Name of witness	Addresses /Contact Numbers

9. Give the names and addresses of the physicians who attended to you for injuries sustained from the accident:

Name of Physician	Addresses of Hospital/Clinic	Date of Attendance							
		From			To				
		Mo.	Day	Year	Mo.	Day	Year		

10. If confined in hospital, please provide history of confinement:

Name of Hospital	Address	Date of Confinement					
		From			To		
		Mo.	Day	Year	Mo.	Day	Year

11. If you are no longer confined but still receiving treatment, please provide:

a. Place of treatment: \_\_\_\_\_

Name of Physician \_\_\_\_\_ Contact numbers: \_\_\_\_\_

Clinic address \_\_\_\_\_

b. Kind of treatment/s: \_\_\_\_\_

**INFORMATION ON YOUR PAST MEDICAL HISTORY (Please answer each question, if not applicable, write N/A)**

1. Give names and addresses of other physicians or such person as a herb doctor (herbolaryo), if any, who had attended you for other previous illnesses or diseases or surgery.

Date of Consultations & Treatments			Dates					
Nature of Illness/injury	Name(s) of Attending Physician(s) or Herb Doctor	Address (es) of Attending Physician(s) or Herb Doctor	From			To		
			Mo.	Day	Year	Mo.	Day	Year

2. Names of your Family Physician

Name of Physician	Addresses /Contact Numbers

Signature of Insured: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Policyholder: \_\_\_\_\_ Date: \_\_\_\_\_

Name and Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Address of Witness: \_\_\_\_\_

SUBSCRIBED AND SWORN to before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_, by the above claimant who exhibited to me his/her government issued ID/Passport No. \_\_\_\_\_, issued at \_\_\_\_\_ on \_\_\_\_\_.

Doc. No. \_\_\_\_\_

Page No. \_\_\_\_\_

Book No. \_\_\_\_\_

Series No. \_\_\_\_\_

NOTARY PUBLIC  
My Commission expires on \_\_\_\_\_

**AUTHORIZATION**

To Whom It May Concern:

This authorizes the Insular Life Assurance, Co., Ltd. or its authorized representative to secure whatever information or record you may have regarding my medical history, accident, and hospital confinement. This authorization is being made in connection with my claim on the insurance policy issued by the said insurance company. I agree that a photocopy of this authorization shall be considered valid.

This authorization discharges you or any authorized member of your staff from any responsibility or obligation in connection with the release of such record or information.

Signature of Insured: \_\_\_\_\_ Date: \_\_\_\_\_

Name and Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_