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 Sickness Form I) is to be used if disability is due to sickness 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 – Sickness Form III);
   2.3. Surgeon's Certification (I-Heal Claim Form IV), if surgery was performed; and,
   2.4. 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.

**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 SICKNESS 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:_____

**Mother's Maiden Name** 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:_____

**Mother's Maiden Name** Given Name:_____ Surname: _____

**INFORMATION ON THE ILLNESS**

Date first symptoms were discovered: _____

Date of first examination/treatment: _____

Date of confinement: _____

**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. Name/s 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:** _____