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

# Insured's Statement
# (I-Shield Claim Form I-A)

**INSTRUCTIONS:**

1. This form is to be completed (if not applicable, please write N/A in the space provided for) by the INSURED and to be submitted together with the following: Hospital's Certification (I-Shield Claim Form II) and Physician's Statement (I-Shield Claim Form III).
2. The following items should also be submitted and will form part of the I-Shield Claim forms:
   2.1 Insured's Hospital records such as, Admitting History, Clinical History and Physical Examination, Discharge Clinical Summary, Results of any Medical Examinations and Laboratory Tests or their equivalent
   2.2 Copy of the Police Report,
   2.3 Sworn Statement of Witness/es.
3. Submit the accomplished Claim Forms together with the item specified above to 18TH Floor, Customer Care Unit, The Insular Life Assurance, Company, Ltd., Insular Life Corporate Center, Insular Life Drive, Filinvest Corporate City, Alabang Muntinlupa City, Tel. Nos. 582-18-18 Loc. 4407 & 4408 or to any of our Insular Life District Offices.

**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.)

To: The Insular Life Assurance Company, Ltd.

I hereby make 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 the furnishing of this form and other claim forms by the Company does not constitute an admission that there is any insurance in force.

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

| Policy number | Name of Insurance Company | Amount of Insurance |
|---|---|---|
| | | |
| | | |

## Part I INFORMATION ON THE INSURED

Name:_____
Surname Given Name Suffix (Sr./Jr., etc)

Mother's Maiden Name:_____
Surname Given Name

| Date of birth | Place of birth | Age at time of accident | Sex | 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 |
|---|---|---|---|
| | | | |

Your present occupation (if more than one, state all)
Job Title/Position:_____
Brief description of job assignment:

Employer's Name:_____
Employer's Address:_____

Office No. Name of Street/ Highway Town/Municipality

City/Province Country Zip Code

Nature of Employer's Business:

| Do you hold any elective position in government at time of accident? ☐ Yes ☐ No | If yes, please state your position and Title: Position Title | Tenure of office: From: To : |
|---|---|---|

**Part II INFORMATION ON THE ACCIDENT (Please answer each question, if not applicable, write N/A)**

1. Date and time of accident
Month Day Year Time

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

3. Give complete history of the accident or how your injury was sustained:

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

5. If you were 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.a During the accident, were you a passenger, driver or pedestrian? _____

6.b If driving or riding a motorcycle, were you wearing a helmet? _____Yes_____No

6.c. If driving or riding a vehicle, were you wearing a seatbelt? _____Yes_____No

6.c Please fill up the following:

| If traveling by land | If traveling by plane or ship |
|---|---|
| Route: _____ | Name of Airline/Shipping Company _____ |
| Name of driver : _____ | Office Address of Airline/Shipping Company: _____ |
| Vehicle type: _____ | _____ |
| Plate number: _____ | _____ |
| Registration year: _____ | Telephone nos. _____ E-mail address _____ |
| **Please attach photocopies of Official Receipt, Certificate of Registration, your Driver's License if you were the one driving (plasticized and renewal receipt of payment).** | **Please attach a certification from the Airline/Shipping Company stating that you were 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 no such investigation was made.

8. Names, addresses and contact numbers of witnesses to the accident:

| Name/s of witness/es | Addresses /Contact numbers |
|---|---|
| | |
| | |
| | |

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

| Name of physician | Addresses of hospital/clinic | Date of attendance | | | | | |
|---|---|---|---|---|---|---|---|
| | | From | | | To | | |
| | | Month | Day | Year | Month | Day | Year |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

10. If confined in hospital, please provide:

| Name of hospital | Addresses | Date of confinement | | | | | |
|---|---|---|---|---|---|---|---|
| | | From | | | To | | |
| | | Month | Day | Year | Month | Day | Year |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**NOTE: PLEASE ATTACH OFFICIAL STATEMENT OF HOSPITAL ACCOUNT AND RECEIPT OF PAYMENT.**

If you are no longer confined but still receiving treatment, please state:

a. Where are you being treated? _____

Name of physician_____ Contact numbers : _____

Hospital/Clinic address_____

b. What kinds of treatment are your receiving: _____

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

1. Give the names and addresses of other physicians, if any, who had attended you for other previous illnesses, diseases or injuries during the past two (2) years.

| Name/s of Physician | Diagnosis | Name/s & address/es of Hospital/Clinic | Date/s of Consultation/s and Treatment/s | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | From | | | To | | |
| | | | Month | Day | Year | Month | Day | Year |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

2. Names of your family physician

| Name/s of physician/s | Address/es and Contact number/s |
|---|---|
| | |
| | |

**Signature of Insured:**_____ **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. _____
Book No. _____
Page No. _____
Series No. _____

NOTARY PUBLIC
My Commission expires on _____

# AUTHORIZATION

To Whom It May Concern:

This authorizes The Insular Life Assurance Company, 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:** _____