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 - Accident Form III) must be completed by the ATTENDING PHYSICIAN of the Insured. (If not applicable, please write N/A in the space provided for.)

2. The following must be submitted, along with this form:
   2.1. Insured's Statement of Claim (I-Heal Claim - Accident Form I), as applicable;
   2.2. Hospital's Certification (I-Heal Claim Form II);
   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.

PHYSICIAN'S STATEMENT
(I-HEAL CLAIM - ACCIDENT FORM III)

1. Name of Patient: _____
   (Given Name) (Surname) (Suffix)

2. Patient's occupation at time of accident:

3. Date & time of accident
   _____
   Month Day Year Time

4. Place of accident
   _____
   Name of Street/Highway City or Municipality Province

5. Date and place you first attended to the patient? _____
   Month/Day/Year Place

6. Describe fully the nature of the injury(ies).

7.1. Was patient, in your opinion, under the influence of liquor, any intoxicating drink or drug at the time of the accident?

7.2. If he was, what caused you to believe this? Please give particulars.

8.1. Please give full details on the nature of treatment/s and/or medical examination/s prescribed to the patient (include findings, diagnosis and prescribed regimen/remedies.)

8.2. Please indicate any disease, illness or abnormality that the patient is suffering from independent of the present injury(ies) sustained.

Nature of disease, illness or abnormality	Inclusive dates of illness	If confined, Name and address of Hospital

8.3. Did the patient himself provide the above information? If not, please indicate name of informant and his relationship to the patient?

8.4. Did the abnormality, disease or illness contribute to the occurrence of the accident or retard in any way the patient's recovery from the accident? If so, please provide details.

9. Is any surgical operation advised to be performed in the future? If so, please provide details.

_____

_____

_____

_____

10. What is/are your final and complete diagnosis?

_____

_____

_____

11. How long has the patient been under your treatment?

From _____ To _____

Month Day Year Month Day Year

I,_____hereby certify that the answers given above are full, complete and true.
(Physician's Full Name)

_____
Physician's Printed Name & Signature
License No.:_____
Valid until:_____

_____
Date Signed

_____
Name and Signature of Witness

_____
Date Signed

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 of_____.

NOTARY PUBLIC
My Commission expires on _____