



## I-Heal

**INSTRUCTIONS TO CLAIMANT:**

1. This form (I-Heal Claim Form IV) must be completed by the ATTENDING SURGEON, if surgery was performed. (If not applicable, please write N/A in the space provided for.)
2. The following must be submitted, along with this form:
  - 2.1. Official Receipt, covering the surgical fee;
  - 2.2. Insured's Statement of Claim (I-Heal - Accident or Sickness Form I, as applicable);
  - 2.3. Hospital's Certification (I-Heal Claim Form II);
  - 2.4. Physician's Statement (I-Heal Claim – Accident or Sickness Form III, as applicable); and,
  - 2.5. 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.

### SURGEON'S CERTIFICATION (I-HEAL CLAIM FORM IV)

Name of Patient:		Age	Gender
_____ <small>(Surname)</small>	_____ <small>(Given Name)</small>	_____ <small>(Suffix)</small>	
Complete Diagnosis:		Short History of Injury/Illness:	
Biopsy/Histopath Result:			
Is the patient under your professional care at present? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Nature of operation performed:			
Date performed:		Hospital/Clinic where the operation was performed:	
Name of Surgeon:			Fees Charged: P
If surgeon is also the attending physician, please indicate the following:  Attending Physician's Charges: _____  Surgeon's Charges: _____  Total Professional Fee: _____  <i>NOTE: If no itemization is indicated, it is assumed that the Surgeon's charges is equal to the Total Professional fee.</i>			
Name of Anesthesiologist:			Fees Charged: P
<b>ATTENDING SURGEON'S DECLARATION</b>			
I HEREBY CERTIFY that the foregoing answers are true, correct and complete.			
SIGNATURE OF ATTENDING SURGEON: _____		DATE SIGNED: _____	
AREA OF SPECIALTY: _____		AREA OF PRACTICE: _____	
LICENSE NO.: _____		VALID UNTIL: _____	