

G/F - 3/F Morning Star Center, 347 Sen. Gil. Puyat Ave., Makati City  
Tel. No.: (632) 890-1758 \* Fax No.: (632) 895-8524 \* website: www.asianlife.com.ph

**IMPORTANT**

To ensure prompt action on your claim, please update the following information:

Telephone No. \_\_\_\_\_  
Cellphone No. \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

**HOSPITALIZATION CLAIM FORM**

INSTRUCTIONS: The insured individual should fill our Part I, either for himself or his dependent and have the Attending Physician fill our Part III on the next page hereto. Then this claim form together with the original copies of the Hospital's and Doctor's statements, charge slips and other pertinent bills and official receipts should be forwarded to the Employer who should fill out Part II thereof and then submit these papers to Asian Life and General Assurance Corporation. Failure to complete requirements may delay payment of your claim.

The COMPANY makes no admission of liability or waiver of rights by furnishing this form.

**PART I TO BE COMPLETED BY THE INSURED INDIVIDUAL (EMPLOYEE OR MEMBER)**

Name of Claimant		Employer		Civil Status	Cert. No.
Present Address				Occupation/Position	
If Claim is for Dependent	Patient's Name		Date of Birth	Relationship	
Resides with Insured Individual?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Married?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Is Dependent Employed?			Occupation/Position		
<input type="checkbox"/> No <input type="checkbox"/> Yes, By Whom?					
When symptom was noticed?	Have you consulted a doctor?		What were the findings/diagnosis?		
	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when				
Name of Physician/s you/patient have you consulted prior to this confinement			Address of the physician/s you/patient have consulted?		

**TO BE ANSWERED ONLY IF INJURY IS DUE TO ACCIDENT**

When and where did this accident happen?  
Please indicate time.

What was the insured person doing when it happened?

State how it happened.

Was the injured person at work when it happened? If so, for whom?  
 Yes  No

Is this patient covered by any other group insurance plan?  Yes  No  
If yes, state with what insurance company.

Was the injured person hospitalized?  Yes  No

Name of Hospital \_\_\_\_\_  
Name of Attending Physician \_\_\_\_\_

I hereby certify that the foregoing statements,, including any accompanying statements are, to the best of my knowledge and belief, true, correct and complete. I hereby authorize any physician to furnish and disclose all known facts concerning this disability AsianLife and General Assurance Corporation or to its authorized representative.

In the event of underpayment or overpayment of claim due to changes in benefits or wrong computation of claim, I and AsianLife and General Assurance Corporation mutually agree to pay or to reimburse the affected party corresponding to the amount involved.

Date \_\_\_\_\_ Claimant's Printed Name and Signature \_\_\_\_\_

**PART II - TO BE COMPLETED BY THE EMPLOYER**

(TO EXPEDITE SETTLEMENT OF THE CLAIM, THE EMPLOYER MUST ANSWER ALL QUESTIONS HEREIN)

**NAME OF EMPLOYER:** \_\_\_\_\_

Claim is made for,  Employee (Name Above)  Spouse of Employee  Son/Daughter of Employee

If Employee is the disabled person, please answer a,b,c, below:

a. When did he stop to work? \_\_\_\_\_ Time: \_\_\_\_\_

b. When did he return to work? \_\_\_\_\_ Time: \_\_\_\_\_

c. If not back at work, when do you expect him to return? \_\_\_\_\_

Did disability occur due to occupational cause or causes  Yes  No

Has claim been filled under Employees Compensation Commission  Yes  No

PLEASE ISSUE REIMBURSEMENT CHECK IN FAVOR OF:

Employee/Claimant  
 Employer  
 Broker

I HEREBY CERTIFY that the foregoing statements are true, correct and complete to the best of my knowledge and belief. I certify further that the employee named-above is a regular full-time employee of our Company in accordance with our records and insured under our Group Hospitalization Insurance Policy issued by AsianLife and General Assurance Corporation. In the event of underpayment or overpayment of the claim due to changes in the benefits or wrong computation of claim, our Company and AsianLife and General Assurance Corporation mutually agree to pay or to reimburse the affected party to the amount involved.

Printed Name \_\_\_\_\_ Signature \_\_\_\_\_ Position/Title \_\_\_\_\_ Date \_\_\_\_\_