ASIANLIFE
& GENERAL ASSURANCE CORPORATION

OUT PATIENT CLAIM FORM

3rd Flr. Morning Star Center,
347 Sen. Gil Puyat Avenue, Makati City
Tel. No. 830-1758 Fax No. 895-8524*

Name of Employee: _____ Date:_____
Name of Patient: _____ Sex: _____ Age _____
Policyholder: _____

Complaints: _____
Treatment/Recommendation: _____
_____
Final Diagnosis: _____

_____ _____
ATTENDING PHYSICIAN'S SIGNATURE
OVER PRINTED NAME

OFFICE ADDRESS & TELEPHONE NO.

_____ _____
EMPLOYEE'S SIGNATURE

EMPLOYER'S SIGNATURE (HRD)

- Please make check payable to _____
(To be filled-up by the Insurance Broker or HRD Head)

Note: Please attached this form to the Orig. Doctor's Prescription and Official Receipts.

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