THE PHILIPPINE PRUDENTIAL LIFE INSURANCE CO., INC.

2nd Floor ERSAN Bldg., #32 Quezon Avenue, Quezon City
Tel. No. 742-7631 to 38; Fax No.: 741-9358
P.O. Box 985, Manila, Philippines

GROUP HOSPITAL INCOME BENEFIT CLAIM FORM

IMPORTANT: *This form shall be accompanied by the Hospital's and Doctor's Statement of Accounts and/or itemized bills, charge tickets and official receipts.*

PART I - TO BE COMPLETED BY THE INSURED CLAIMANT

1. Name of Claimant : _____ Cert. No. : _____
2. Present Address : _____ Tel. No. : _____
3. If claim is made for Dependent:
   Name: _____ Relationship : _____
   Date of Birth: _____ Sex : _____
   Is dependent presently employed? Yes ____ No ____ Civil Status : _____
   If "yes" Name of Employer _____
4. Please answer if injury is due to Accident
   a) Describe the accident - How it happened? _____
   _____
   b) When and Where did the accident happen? _____
   c) Was the insured person at work when the accident happened? Yes ____ No ____
5. a) Was the insured person hospitalized? Yes ____ No ____ If so, Name of Hospital _____
   b) Name of Attending Physician: _____
6. Is the insured person entitled to receive compensation under the Labor Laws? Yes ____ No ____
   a) Is he claiming benefits under another health insurance? Yes ____ No ____
   b) If "Yes", state with what insurance company or under what employer's prepayment plan: _____
   _____

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 to Philippine Prudential Life Insurance Co., Inc., or to its authorized representative.

Date: _____ _____
Claimant's Signature

PART II - TO BE COMPLETED BY THE AUTHORIZED OFFICER OF THE POLICYHOLDER / EMPLOYER

NAME OF POLICY / HOLDER _____

1. Claim is made for: _____ Employer (Name Above) _____ Spouse _____ Child
2. If Employee is sick
   a) First day unable to work: _____ at _____ AM _____ PM
   b) Date resumed work : _____ at _____ AM _____ PM
3. Did disability occur due to occupational causes or in the course of employment? Yes ____ No ____
4. Has claim been or will be filed under the Labor Laws? Yes ____ No ____
5. Has there been any previous claim filed for this person's confinement? Yes ____ No ____

REMARKS:

_____ _____ _____
Date Sign over Printed Name Title / Position

PART III - THIS IS TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. Patient's Name: _____ Age: _____ Sex: _____
2. Did this sickness / injury occur during the course of his employment? Yes ____ No ____
3. Was patient hospitalized? Yes ____ No ____
   a) Name of Hospital _____ Address: _____
   b) Is this hospital / clinic registered with the Bureau of Medical Services? Yes ____ No ____
   c) If not, does it have a permit to operate such to admit in-patient? Yes ____ No ____
   d) Registered / Permit No. _____ Date Issued: _____ Issued by: _____
4. History of Illness or Injury in detail: _____

FINAL DIAGNOSIS: _____

5. Date Admitted: _____ at _____ AM/PM Date Discharged: _____ at _____ AM/PM

6. List X-ray, Laboratory or other services done

WHAT	WHERE	WHEN	AMOUNT	FINDINGS

7. Drugs and Medicines administered in the hospital / clinic:

Name of Drugs / Medicines	Dosage of / No. of	Quantity	Unit Cost

	PLACE	DATE	PER CALL	TOTAL
8. Give dates of treatment Office				
And medical fees charged home				

ATTENDING PHYSICIAN : _____

SIGNATURE : _____

PTR NO. : _____

The Philippine Prudential Life Insurance Co. Inc.

Personal Accident Insurance Claim

CLAIMANT'S STATEMENT

Instructions: Every question must be fully answered. The company reserves the right to require additional information if deemed necessary.

Full Name of Claimant: _____

Residence: _____

Relationship to the insured: _____

Full Name of Insured: _____ Date of Birth: _____

Employer: _____

Date of Accident: _____ Place of Accident: _____

Nature of injuries sustained: _____

Period in which you were not able to perform: _____

State what happened (You can use the back portion for additional information)

_____

_____

_____

_____

Name of attending Physician: _____

Name of hospital / clinic: _____

Complete address of hospital/ clinic: _____

_____

Are you entitled to receive compensation from government sources? Yes ☐ No ☐

If yes, check with agency & how much? ○ SSS _____ ○ GSIS _____

○ Medicare _____ ○ ECC _____

Are you entitled to receive compensation from other private insurance companies or health maintenance organization (HMO)? Yes ☐ No ☐

If yes, state the name of the insurance company/ies or HMOs and the amount you are entitled to.

COMPANY/IES	AMOUNT

I hereby certify that all the statement above are true and correct to the best of my knowledge and that I have not concealed any material fact from Philippine Prudential Life Insurance Co. Inc. Thereby further authorize any hospital, physician, or other person who has attended or examined me, to furnish Philippine Prudential Life Insurance Co. Inc. or its authorized representative, and all information with respect to an illness or injury, medical history consultation, prescriptions or treatment and copies of all hospital or medical records. A photocopy of this authorization is considered effective and valid as the original.

_____

PRINT NAME OF CLAIMANT & SIGN OVER PRINTED NAME

Documents submitted together with this claimant's statement:

- Attending physician statement
- ORIGINAL official receipt/s
- Statement of account from hospital / clinic
- Itemized list of laboratory examination performed, supplies and medicines used with their corresponding cost
- Original doctor's prescription, if medicine was bought outside the hospital
- Police report / incident report, as applicable

The Philippine Prudential Life Insurance Co. Inc.
Personal Accident Insurance Claim

ATTENDING PHYSICIAN'S STATEMENT

IMPORTANT: Every question must be fully answered. If the space provided is not enough, you can use the back portion of this form. The company reserves the right to require further information should it be deemed necessary.

Full Name of Physician:_____

Residence of Physician:_____

Full Name of Insured:_____ Sex: ☐ Male ☐ Female Age:_____

Full particulars of injury/ies caused by accident. Be specific. Describe complications, if any. (Use the back portion of this form for additional information.)_____

_____

Is the insured suffering from any other disease/s and/or infirmity/ies which may have led to present condition? Yes ☐ No ☐

If yes. please give details. (Use the back portion of this form for full explanation, if necessary)

_____

_____

_____

Was there any surgical procedure done? Yes ☐ No ☐

If yes, give details (Use the back side of this form for additional information.)

_____

_____

What is your prognosis?_____

Is there a lost of sight? Yes ☐ No ☐ *If yes, please indicate wether* ○ right eye ○ both ○ left eye

Is the lost of sight ○ Total ○ Partial ○ Recoverable ○ Irrecoverable

Is there a dislocation or fracture of the bones? Yes ☐ No ☐

If fracture of long bones, is the fracture through ○ shaft or ○ Extremity Confirmed by X-rays ☐ Yes ☐ No

Did you attend to the patient for other illness/injuries prior to this accident? Yes ☐ No ☐

If Yes, please give details. (for what illness, inclusive of dates)_____

Was the patient treated as out-patient? Yes ☐ No ☐

If not, please indicate:

Date confirmed:_____ Date discharged:_____

Name of hospital / clinic:_____

The patient is ○ totally disabled ○ temporary disabled For how long?_____

When will the patient be able to return to work?

I hereby certify statements are true and correct to the best of my knowledge and belief, and that there are no materials facts in the case which are not disclosed.

_____
NAME & SIGNATURE OF ATTENDING PHYSICIAN

Date:_____

THE PHILIPPINE PRUDENTIAL LIFE INSURANCE CO., INC.

Suites 305-308, 3rd Floor, AIC Burgundy Empire Tower
ADB Avenue corner Garnet & Sapphire Roads
Ortigas Center, Pasig City

IDENTIFICATION

POLICY NO.: _____

This form is to be accomplished by a competent person acquainted with the deceased, fully aware of his/her death, but not interested in the claim.

1. (a) Deceased's full name _____
   (b) Res. Address at the time of death _____
   (c) Occupation at death _____
   (d) Place and date of birth _____

2. (a) Place of death _____
   (b) Date and time of death _____
   (c) Cause of death _____
   (d) Place of interment _____
   (e) Date of interment _____

3. (a) How long have you known the deceased? _____
   (b) Have you seen the cadaver of the deceased? _____
   (c) Was it the cadaver (body) of the person insured under the policy numbered above? _____
   If so, please give basis for your identification _____
   _____

4. Do you guarantee that these statements are true and correct to the best of your knowledge and belief?

Dated at _____ this _____ day of _____, 20___.

Signed in the presence of:

1. _____ _____
   Witness — Name in Print & Signature

   _____ _____
   Address — Occupation

   _____ _____
   Witness — Name in Print & Signature

   _____ _____
   Address — Occupation

THE PHILIPPINE PRUDENTIAL LIFE INSURANCE CO., INC.

Suites 305-308, 3rd Floor, AIC Burgundy Empire Tower
ADB Avenue corner Garnet & Sapphire Roads
Ortigas Center, Pasig City

CLAIMANT'S STATEMENT

POLICY NO.: _____

1. (a) Deceased's name in full _____
   (b) Residence at death _____
   (c) Occupation at death _____

2. (a) Deceased's date of birth _____
   (b) Place of birth _____
   (c) Your sources of the above information _____

3. (a) Date of death _____
   (b) Place of death _____
   (c) Cause of death _____

4. (a) When did deceased first complain of or give indication of his last illness? _____
   (b) When did deceased first consult a physician for his last illness? _____
   (c) Names and addresses of all physicians who attended the deceased in his last illness: _____

5. Facts concerning other life and accident insurance carried by deceased:

Company	Policy No.	Amount of Insurance

6. Your date of birth _____
   Your relationship to the deceased _____

Having been duly sworn, I hereby depose and say that the statement in the foregoing answers are true and full, to the best of my knowledge and belief and that there are no material facts in the case which are not disclosed.

Dated at _____ this _____ day of _____, 20___.

_____ Witness

_____ Claimant

_____ Address

_____ Address

On this _____ day of _____, 20____, personally appeared before me the above named _____, with Res. Cert. No. _____ issued on _____ at _____ to me known, who being by me duly sworn, deposed that the answer to the above questions and subscribed the same in my presence.

NOTARY PUBLIC
My Commission Expires _____

Doc. No. _____ Page No. _____ Book No. _____

In proof of Me Siong submitted
to the PHILIPPINE PRUDENTIAL LIFE INSURANCE CO., INC. at the claimant of Policy No. _____.

PHYSICIAN WILL PLEASE READ IMPORTANT NOTICE ON BACK OF THIS SHEET

This Statement must be made by the Physician in attendance during the last illness of the deceased, and must be entirely in his own handwriting. If more than one physician was employed, the statement of each must be finished upon separate forms, which will be sent if required.

When an autopsy has been made by order of the court, a copy of the verdict, and of the evidence upon which it was based duly certified must be furnished.

1. Name of the deceased in full

2. Residence

3. Last Occupation of the deceased

4. How long did you attend the deceased?

5. Did you attend or were you consulted by the deceased before the last illness? If so, when and for what illness, giving details including dates.

6. A. Did you attend the deceased during his last illness?
   B. If so, for what disease?
   A. _____
   B.

7. A. Date and hour of your first visit
   B. Date and hour of your last visit
   A. _____
   B.

8. A. Did any other physician attend the deceased during last illness?
   B. Give name and address of each date of his first visit and the duration of his attendance.
   A. _____
   B.

9. A. Place of death
   B. Date of death
   A. _____
   B.

10. A. What disease was the immediate cause of death?
    B. How long in your opinion, did the deceased suffer from this disease?
    A. _____
    B.

11. A. What were the first indications of failing health?
    B. When were they first noticed? Give date and hour if possible.
    A. _____
    B.

12. A. From what other disease if any, did the deceased suffer?
    B. Give as nearly as you can, the duration of each one.
    A. _____
    B.

13. Did previous illness, family history or habits in any way predispose the deceased to the cause of death? If so, describe fully.

14. For how long before death occurred as the deceased confined to the house or prevented from attending to business?

15. From physical findings and appearances, what would you judge to be the age of the deceased?

16. A. Was death caused, directly or indirectly, by the habits, occupation? A. _____
B. Does the deceased use alcoholic beverage of any kind? If so, to what extent or effect? B.

17. A. Where did you receive your medical education? A. _____
B. When and where did you graduate? B.

18. A. Was there an autopsy or a post-mortem examination on the body of the deceased? A. _____
B. If so, state which, by whom and give the result. B.

19. Did you personally see the remains of the deceased?

20. Do you guarantee that all the statements and answers made by you in this questionnaire are true and that you have not concealed any material fact from the Company?

Having been duly sworn, I hereby depose and say that the statement in the foregoing answers are true and full, to the best of my knowledge and belief, and that there are no material facts in the case which are not disclosed.

Dated at _____ this _____ day of _____, 20____.

_____
Witness

_____
Address

_____
Attending Physician

_____
Address

On this _____ day of _____, 20___, personally appeared before me the above named _____ to me known as a physician in regular standing, who being by me duly sworn, and subscribed the same in my presence; affiant exhibited to me his Residence Cert. No. _____ on _____, 20_____.

Doc. No. _____
Page No. _____
Book No. _____
Series of 20_____.

NOTARY PUBLIC

THIS STATEMENT SHOULD BE SWORN TO BEFORE A NOTARY PUBLIC OR OTHER DULY AUTHORIZED TO ADMINISTER OATHS AND HIS OFFICIAL SEAL ATTACHED, OR IF HE HAS NO SEAL, HIS AUTHORITY AND THE GENUINENESS OF HIS SIGNATURE MUST BE ATTESTED BY A JUSTICE OF THE PEACE OR BY A CLERK OF A COURT OF RECORD.

IMPORTANT NOTICE

The physician who fills this blank will facilitate the PROMPT PAYMENT or THE CLAIM by giving in answer to Questions No. 10, 11, 12, 13, 14 and 16, a full statement of each. Pathological process especially as to its Duration and results.

Such indefinite terms as Heart Failure, Exhaustion and the like, are to be avoided unless full details are added.

Where death is the result of Accident or Injury, the word LESION may be understood to replace DISEASE in question 10.

Where the spaces set apart for the answers are too small, such details as seem desirable may be given on this page, under ADDITIONAL REMARKS.