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 I Website: www.insularlife.com.ph
Tel.: (632) 8-582-1818 I VAT REG. TIN 000-464-124-000

Hospitalization Claim Form

INSTRUCTIONS: (1) This hospitalization claim is to be accomplished in full (all questions answered and signed) by the following: INSURED (Part I); Authorized Representative of the hospital (Part II); and, Attending PHYSICIAN (Part III). (2) In case of hospital confinement due to accident, the following items should also be submitted: (2.1) copy of the police report and/or (2.2) sworn statement of at least an eyewitness. (3) Submit the accomplished hospitalization claim form together with the item specified above to POLICY FULFILLMENT DEPARTMENT, THE INSULAR LIFE Assurance, Co., Ltd., Insular Life Corporate Centre, Insular Life Drive, FIlinvest Corporate City, Alabang, 1781 Muntinlupa.

PART I: INSURED'S STATEMENT

Given Name: Surname: Suffix:	Address:	Tel. No.:
Policy No./s: _____ Effective Date: _____	Date of Birth: _____ Occupation: _____	Age: _____ Sex: _____
Name of Hospital:	Address:	Tel. No.:
For confinement due to sickness: Date First symptoms discovered: _____ Date of First Examination/treatment: _____ Name/s and address/es of all physicians who attended you _____ _____ _____ _____	For confinement due to accident: Date and time of accident: Month: _____ Day: ____ Year: ____ Time: ____ Place of Accident: _____ Describe fully the nature of ailment/injury sustained: _____ _____ _____ _____	

A. Declaration

I hereby certify that to the best of my knowledge and belief, the foregoing and accompanying statements are complete and accurate.

I understand that the furnishing of this form and other claim forms by the Company does not constitute an admission that there is any insurance in force.

B. Data Privacy Statement

I understand that as a financial institution, Insular Life is subject to existing and future government regulations. I therefore agree to be bound by all applicable domestic and international laws in relation to any matter including but not limited to anti-money laundering, tax monitoring and data privacy.

In this connection, I authorize Insular Life to process my personal and sensitive personal information (also known as personally identifiable information or PII) including the collection, usage, storage, retention, and disclosure of my PII in the related processes and systems until its disposal. I likewise give my consent to Insular Life to share such information to its subsidiaries, affiliates, agents, medical information sharing facility of the insurance industry and third parties for any legitimate purpose, including the underwriting and administration of insurance coverage and claims, marketing and promotion of products, market research, data analytics and automated processing systems, internal and external audits, and such activities for which my PII may be required in fulfillment of mandated services across my entire life stages.

I/We also confirm that I/we have sought the consent of the insured and/or the beneficiary/ies in sharing his/her personal and sensitive personal information, as may be applicable.

I hold Insular Life free and harmless from any liability that may arise from any collection, use, disclosure, destruction or sharing of said information.

C. Authorization

In relation to the claims application for the illness, injury and/or death of the Owner or Insured under this/these Policy/ies, I/We hereby authorize The Insular Life Assurance Co., Ltd. ("Company") or its authorized representative to secure any information and/or record belonging to the Policy Owner or Insured, as the case may be, under this/these Policy/ies pertaining to the following:

1. financial, employment/business/livelihood,
2. health, both physical and mental,
3. lifestyle,
4. Court (criminal, civil or administrative) records,
5. personal or
6. other circumstances

from any of his/her employers, business partners, co-employees, staff, consultants, physicians, or from any hospital, clinic, health maintenance organization, diagnostic center, laboratory or any similar medical facility, any private or government agency or institution, organization, insurance industry association or from any individual person that may have knowledge, access to or custody of any such information or record.

I/We likewise authorize the foregoing individuals or entities that have/had knowledge, access to or custody of any of the abovementioned information or record to disclose and release the same to Insular Life or its representative and further hereby discharge them from any responsibility, obligation or liability arising out of or in connection with such disclosure and release of the information or record.

_____ _____

SIGNATURE OVER PRINTED NAME OF INSURED DATE

PART II: HOSPITAL'S AUTHORIZED REPRESENTATIVE'S STATEMENT		
Name of Patient:		
Date of Birth:	Age:	Sex:
Diagnosis/Nature of Illness/Injury:		
Hospital Confinement recommended or sought by:		
Date Admitted:	Time Admitted:	
Date Discharged:	Time Discharged:	
Name of Hospital:		
Address:	Tel. No.:	
Registration/Permit No.:	Date Issued:	Issued By:
I hereby certify that the foregoing statement is, to my knowledge and belief, complete and accurate: SIGNATURE: Date:		
Name of Representative: Official Title:		
NOTICE TO HOSPITAL: Attach the patient's hospital chart or clinical chart record and the Statement of Account signed by your authorized officer together with all other bills and/or receipts covering hospital charges incurred during confinement.		

PART III: ATTENDING PHYSICIAN STATEMENT	
Name of Patient:	
Period of Hospital Confinement: From: To:	
Complete Diagnosis/Prognosis:	
Have you advised patient of your finding? If not, Why?	
Medical Treatment Given:	
Is any surgical operation, contemplated or has been performed? If so, What? _____ When? _____ Where? _____ By Whom? _____	
Have you previously attended him? If so, WHEN? FOR WHAT?	
When, in your opinion, can he resume his usual occupation or employment?	
I hereby certify that the foregoing statements are true, complete & correct according to my knowledge and belief. SIGNATURE: Date:	
Name of Physician:	
PTR No.:	Tel. No.:

WARNING: It is unlawful (a) to present or cause to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and (b) to fraudulently prepare, make or subscribe any writing with intent to present or use the same, or to allow it to be presented in support of any claim. Such acts shall be punishable by a fine not exceeding twice the amount claimed or imprisonment of two (2) years, or both, at the discretion of the court. (Section 251, Insurance Code.)