



HOSPITALIZATION CLAIM FORM

Hospitalization Claim Form

INSTRUCTIONS: (1) This hospitalization claim is to be accomplished in full (all questioned 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 injury, the following item should be submitted with the accomplished hospitalization claim form, and will form part of the said hospitalization claim: (2.1) copy of the police report (if injury is sustained in a vehicular accident); or (2.2) sworn statement of at least an eyewitness (if injury is sustained other than in a vehicular accident). (3) Submit the accomplished hospitalization claim form together with the item specified above to POLICY BENEFITS 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		
Name:	Address:	Tel. No.:
Policy No: _____ 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: _____	For confinement due to accident: Date and time of accident: _____ Place: _____ Details of injury/ies sustained: _____	
<p>I hereby certify that, to the best of my knowledge and belief, the foregoing and accompanying statements are complete and accurate. I authorized any physician, hospital, clinic and other medically related facility and any eyewitnesses to furnish the INSULAR LIFE Assurance Company Ltd., or its duly authorized representative with any and all information concerning my hospital confinement, including, my medical history. This information is to be used in connection with my proof of loss under my Insurance Policy. I agree that photostatic, xerox, and/or u-bix copies of this authorization shall be considered valid.</p>		
_____		_____
SIGNATURE		DATE

PART II: HOSPITAL'S AUTHORIZED REPRESENTATIVE'S STATEMENT			PART III: ATTENDING PHYSICIAN STATEMENT		
Name of Patient:			Name of Patient:		
Date of Birth:	Age:	Sex:	Period of Hospital Confinement: From: _____ To: _____		
Diagnosis/Nature of Illness/Injury:			Complete Diagnosis/Prognosis:		
Hospital Confinement recommended or sought by:			Have you advised patient of your finding? If not, Why?		
Date Admitted:	Time Admitted:		Medical Treatment Given:		
Date Discharged:	Time Discharged:		Is any surgical operation, contemplated or has been performed? If so, What? _____ When? _____ Where? _____ By Whom? _____		
Name of Hospital:			Have you previously attended him? If so, WHEN? _____ FOR WHAT? _____		
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:	When, in your opinion, can he resume his usual occupation or employment?		
Name of Representative:			I hereby certify that the foregoing statement is, to my knowledge and belief, complete and accurate.		
Official Title:			SIGNATURE: _____ Date: _____		
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.			Name of Physician:		
CLAIM NO.		For Home Office Use:	PTR No.:		Tel. No.: