PARAMOUNT
LIFE & GENERAL
INSURANCE

14th Floor, Sage House, 110 V.A. Rufino St.,
Legaspi Village, Makati City, 1229 Philippines
Tel. No.: +(632) 8772 9200
Fax No.: +(632) 8772 9297
www.paramount.com.ph

HOSPITALIZATION CLAIM REQUIREMENTS

1. **Original or Certified True Copy of Hospital Bill**
2. **Original Official Receipts Covering Payment of Hospital Bills as indicated in the Statement of Account**
3. **Original Professional Fee Receipt/s**
4. **Original Official Receipts of Medicines Bought Outside of the Hospital but within Confinement Period only**
5. **Record of Operation or Admitting History with Discharged Summary**
6. **Traffic Accident Report Sketch**
   (if cause of hospitalization was due to Vehicular Accident)
7. **Photocopy of Driver's License**
8. **Photocopy of latest payslip / Medical Certificate**

Note: Additional requirements may be requested depending on the circumstance/ cause of hospitalization and evaluation of our Claims Department.

CLAIMANT'S STATEMENT

This form is to be filled by the claimant. Please do not sign on a blank form. No fees, commission or charges of whatever nature are payable to Agents or Employees of the Company in respect of this claim.

Date (mm/dd/yyyy):	Policy / Certificate Number/s:

INSURED CLAIMANT INFORMATION

Name of Claimant:	
Date of Birth: (mm/dd/yyyy)	Place of Birth:
Present Address:	
Telephone No.:	Present Occupation:

If claim is made for Dependent:

Name:		
Name:	Relationship	Gender / Civil Status
Is dependent presently employed? ☐ Yes ☐ No If yes, Name of Employer:		

Please answer if injury is due to Accident:

Describe the accident: How it happened?
When and Where did the accident happen?
Was the insured person at work when the accident happen? ☐ Yes ☐ No

State how it happened?

Was the insured hospitalized? ☐ Yes ☐ No

Name of Hospital:

Address:

Name of Attending Physician:

Is insured person entitled to receive compensation under the Labor Laws? ☐ Yes ☐ No

Is he claiming benefits under another health insurance? ☐ Yes ☐ No

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 authorized any physician to furnish and disclosed all known facts concerning this disability to Paramount Life & General Insurance Corporation, or to its authorized representative.

Claimant's Signature Over Printed Name   Date   Place

PHYSICIAN'S STATEMENT

Patient's Name:	Age:	Gender:

Did this sickness/injury occurred during the course of his employment? ☐ Yes ☐ No

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 as such to admit in-patient? ☐ Yes ☐ No

d. Registration/Permit No:	Date Issued	Issued by:

History of Illness or Injury in details:

Final Diagnosis:

Date Admitted:	at (AM/PM)	Date Discharged:	at (AM/PM)

List X-ray, Laboratory or other services done:

What	Where	When	Amount	Findings

Drugs and Medicines administered in the hospital/clinic:

Name of Drug	Dosage or No. of Time Administered	Quantity	Unit Cost

Give dates of treatment and medical fees charged

PLACE	DATES	PER CALL	TOTAL
Office			
Home			
Hospital			
Nature of Surgical or Obstetrical Procedure, if any:			

If performed in Hospital

a. Date Performed:	check whether as ☐ IN PATIENT ☐ OUT PATIENT
b. Performed by:	Amount charged:
The patient has been continuously disabled:	Amount charged:

The patient has been continuously disabled:

From:	To:	When should patient be able to return to work?

Signed at ____ this _________________ day of ________________ 20 ________

Name Of Attending Physician (IN PRINT) ______________________

Signature ______________________

License No. / Expiry ______________________

Address ______________________

Telephone Number ______________________

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PAYMENT INSTRUCTION

☐ **Credit to my Bank Account**

Bank: ______________________ **Branch:** ______________________

(NOTE: If the account you specify is with a bank other than BPI or BDO, applicable charges may be deducted from the proceeds

Type of Account: ☐ Savings ☐ Checking **Account Currency:** ☐ Peso ☐ Dollar

Account Name : ______________________

Account Number : ______________________

I certify that I am the Owner/Insured/Beneficiary/Group Policyholder/Assignee under Policy Contract/Insurance Certificate Number ______________________ with **Paramount Life & General Insurance Corporation** and that I am the owner of the above elected Bank Account. I hereby certify to the veracity of the bank details provided and any discrepancy may cause a delay in the crediting of the claim proceeds to the account. Any changes in the bank information shall be made by written notification to Paramount Life.

I agree that the crediting by Paramount Life to my bank account herein designated of the amount that may be due to me representing the full and final settlement of the claim, I hereby release and quit any all further claims of the proceeds of the life insurance and the supplementary benefit against Paramount Life, its successors and assigns, its officers and employees. I further agree to protect and save harmless, PARAMOUNT LIFE AND GENERAL INSURANCE CORPORATION from any and all consequence of said action and warrant to defend forever, said action against any and all persons who may assert any right for said amount or file any adverse claim thereon, and to reimburse the Company, of whatever payment it may make or damages and expenses it may incur by reason of such action or in event a case is filed against them for collection of the amount.

______________________ ______________ ______________________
Claimant's Signature Over Printed Name | Date | Place

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DATA PRIVACY CONSENT STATEMENT

For the purpose of processing my insurance claim on the Insurance Certificate/Policy issued by Paramount Life & General Insurance Corporation (hereafter, "PLGIC"), I hereby consent to:

a. the communication or transmittal of my medical information, medical records, and/or medical history, regarding the illness or injury for which I have been treated, by any physician, clinic or hospital and its authorized personnel, or any other natural or juridical person, to PLGIC, its branches, officers, employees, or agents;
b. the communication or transmittal of my other sensitive personal information in relation to aforementioned illness or injury, by any physician, clinic or hospital and its authorized personnel, or any other natural or juridical person, to PLGIC, its branches, officers, employees, or agents;
c. the processing of the personal data stated above, whether manually or via electronic channels, including but not limited to the collection, usage, storage, recording, customer/client profiling, and disclosure to third parties by PLGIC, its branches, officers, employees, or agents; and
d. the processing of the personal data stated above whether manually or via electronic channels, including but not limited to the collection, usage, storage, recording and customer/client profiling, by authorized third parties by PLGIC, its Branches, office employees, or agents, and

I further consent that the medical information and/or records provided shall be retained by PLGIC for at least five (5) years or for a longer period if the same is required to be preserved for litigation or to comply with legal or regulatory requirement. I likewise consent to the correction, amendment, deletion and/or disposal by PLGIC and other persons above-mentioned of these information/records which may be inaccurate or incorrect. I attest that I have been made aware of and understood my rights as data subject and how these can be exercised, and that I was informed of the nature, extent and processing of the personal data I provided.

ANTI-FRAUD WARNING
Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.

DISCLOSURE: In accordance with the Insurance Commission's Circular Letter No. 2016-54 your medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the Insurance Commission's website at www.insurance.gov.ph.

For inquiries or concerns relating to the privacy and security of your personal data or information submitted to Paramount Life & General Insurance Corporation (PLGIC), please contact:

The Data Protection Officer
15th Floor, Sage House Building, 110 V.A. Rufino Street, Legaspi Village, Makati City 1229
E-mail: dataprotectionofficer@paramount.com.ph
Tel No. : +632 8772 9267
Mobile No.: +639176764846

Claimant's Name in Full:
(Last Name, First Name, Middle Name ______________________

______________________ ______________ ______________________
Claimant's Signature Date Place