RESET / CLEAR FORM

PARAMOUNT
LIFE & GENERAL
INSURANCE

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HOSPITALIZATION INSURANCE BENEFIT CLAIM FORM

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

PART I – TO BE COMPLETED BY THE INSURED CLAIMANT			
1. Name of Claimant:	Date of Birth:	Present Occupation:	
2. Present Address:	Certificate No.	Telephone No.	
3. IF CLAIM IS MADE FOR DEPENDENT:			
Name:	Relationship:	Date of Birth	Sex/Status
Is dependent presently employed? ☐ Yes ☐ No	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? ☐ Yes ☐ No	c. Was the insured person at work when the accident happen? ☐ Yes ☐ No		
d. State how it happened?			
5. a. Was the insured hospitalized? ☐ Yes ☐ No	b. Name of Attending Physician:		
Name of Hospital:	Address:		
6. Was insured person previously hospitalized?	Name of Attending Physician:		
Name of Hospital:	Address:		
7. a. Is insured person entitled to receive compensation under the Labor Laws? ☐ Yes ☐ No	b. Is he claiming benefits under another health insurance? ☐ Yes ☐ No		
If yes, state with what insurance company or under what employer's prepayment plan?			

DATA PRIVACY CONSENT STATEMENTS

I hereby consent to the processing of the personal data stated above whether manually or via electronic channels, including but not limited to the collection, usage, storage, and disclosure to third parties, by Paramount Life & General Insurance Corporation (hereafter, "PLGIC"), its subsidiaries, affiliates, directors, officers, employees, and agents (a) to verify and/or confirm any information provided or representation made, (b) to provide, facilitate, monitor and improve the quality of services offered or may be offered by PLGIC, (c) for customer/client profiling, and (d) for marketing purposes. I likewise consent to the processing of the personal data stated above whether manually or via electronic channels, including but not limited to the collection, usage, and storage by authorized third parties for the foregoing purposes.

Such processing may be conducted for the duration of my availment of PLGIC's products, services, facilities and/or channels. I further consent that the personal data stated above shall be retained by PLGIC for an additional period of at least five (5) years, or for a longer period if the personal data is related to or 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, its subsidiaries, affiliates, directors, officers, employees, agents, and authorized third parties, of the personal data which may be inaccurate or incorrect.

I understand and agree that the consent hereby given may be revoked or withdrawn through formal written notice to PLGIC.

_____ Date

_____ Claimant's Signature

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

NAME OF POLICYHOLDER: _____

1. Claim is made for: ☐ Employee (Named Above) ☐ Spouse ☐ Child	
2. If Employee is the sick person a. First day unable to work: _____ at _____AM _____ PM b. Date resumes to work: _____ at _____AM _____ PM	
3. Did disability occur due to occupational cause or in the course of employment? ☐ Yes ☐ No	4. Has Claim been or will be filed under the Labor Laws? ☐ Yes ☐ No
5. Have there been any previous claim filed for this person's confinement? ☐ Yes ☐ No If yes, give approximate date:	REMARKS:

_____ _____ _____

Date | Signature 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 as such to admit in-patient? ☐ Yes ☐ No	
d. Registration/Permit No.	Date Issued:	Issued by:
4. History of Illness or Injury in details:		
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 Drug	Dosage or No. of Time Administered	Quantity	Unit Cost

8. Give dates of treatment and medical fees charged

PLACE		DATES	Per Call	Total
Office				
Home				
Hospital				

9. 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:
c. Name of Anesthesiologist:	Amount Charged:	
10 a. The patient has been continuously disabled: **FROM _____ TO _____**	**b. When should patient be able to return to work?**	

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."

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

_____ _____

Name Of Attending Physician Attending Physician's Signature

_____

License No./Expiry Date

ADDRESS	TELEPHONE NO.

NOTE: PLEASE RETURN THIS FORM TO THE INSURED