PROVIDE THE FOLLOWING DETAILS FOR US TO SETTLE YOUR CLAIM:

Via Bank Fund Transfer
Name of Bank: _____
Account Number: _____
Via Gcash /Maya: _____
Account number: _____
Name: _____
Email Address: _____

HOSPITALIZATION CLAIM FORM

IMPORTANT

To ensure prompt action on your claim, please update the following information:

Telephone No: _____ Cell phone No: _____ E-mail address: _____

INSTRUCTIONS: The insured individual should fill out Part I for himself or his dependent and have the Attending Physician fill out Part III on the next page. Then, this claim form, together with the original copies of the Hospital's and Doctor's statements, charge slips, and other pertinent bills and official receipts, should be forwarded to the employer, who should fill out Part II and then submit these papers to Etiqa Philippines. Failure to complete the requirements may delay payment of your claim.

The COMPANY makes no admission of liability or waiver of rights by furnishing this form.

PART I - TO BE COMPLETED BY THE INSURED INDIVIDUAL (EMPLOYEE OR MEMBER)

Name of Claimant	Employer	Civil Status	Cert. No.

Present Address	Occupation/Position

If Claim for Dependent	Patient's Name	Date of Birth	Relationship

Resides with Insured Individuals? ☐ Yes ☐ No | Married? ☐ Yes ☐ No | Sex ☐ Male ☐ Female

Is Dependent Employed? ☐ No ☐ Yes, By Whom?	Occupation/Position

When was symptom noticed?	Have you consulted a doctor? ☐ Yes ☐ No If yes, when	What were the findings/diagnosis?

Name of Physician/s you/patient have consulted prior to this confinement	Address of the physician you/patient has consulted?

TO BE ANSWERED ONLY IF INJURY IS DUE TO AN ACCIDENT

When and where did this accident happen?
Please indicate time.

What was the insured person doing when it happened?

State how it happened

Is this patient covered by any other group insurance plan? ☐ Yes ☐ No
If yes, state what insurance company.

Was the injured person hospitalized? ☐ Yes ☐ No	Name of Hospital Name of Attending Physician

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 Etiqa Philippines or to its authorized representative.

In the event of underpayment or overpayment of claim due to changes in benefits or wrong computation of claim, I and Etiqa Philippines mutually agree to pay or to reimburse the affected party corresponding to the amount involved.

Date	Total Amount of Official Receipt/s	Claimant's Printed Name and Signature

PART II - TO BE COMPLETED BY THE EMPLOYER
NAME OF EMPLOYER:

(TO EXPEDITE SETTLEMENT OF THE CLAIM, THE EMPLOYER MUST ANSWER ALL QUESTIONS HEREIN)

Claim is made for, ☐ Employee (Name Above) ☐ Spouse of Employee ☐ Son/daughter of Employee

If Employee is the disabled person, please answer a, b, and c below:

a. When did he stop to work? _____ Time: _____
b. When did he return to work? _____ Time: _____
c. If not back at work, when do you expect him to return? _____

Did disability occur due to occupational cause or causes ☐ Yes ☐ No

Has claim been filed under Employees Compensation Commission ☐ Yes ☐ No

PLEASE ISSUE REIMBURSEMENT CHECK IN FAVOR OF:

☐ Employee/Claimant
☐ Employer
☐ Broker

I HEREBY CERTIFY that the foregoing statements are true, correct, and complete to the best of my knowledge and belief, I certify further that the employee named above is a regular full-time employee of our Company in accordance with our records and insured under our Group Hospitalization Insurance Policy Issued by Etiqa Philippines. In the event of underpayment or overpayment of the claim due to changes in the benefits or wrong computation of claim, our Company and Etiqa Philippines mutually agree to pay or to reimburse the affected party to the amount involved.

Printed Name	Signature	Position/Title	Date

Etiqa Life and General Assurance Philippines, Inc.
Etiqa Atrium, 10th to 12E Floors, 107 Aguirre St.
Legazpi Village, Makati City 1229
Tel. No: (632) 8890-1758

PART III - TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Name of Patient	Birthdate	Age	Cert. No.

Was the patient hospitalized? ☐ Yes ☐ No	Hospitalized at:
Is this hospital/clinic registered with the Bureau of Medical Services? ☐ Yes ☐ No	If not, does it have a permit to operate as a hospital/clinic and to admit patients? ☐ Yes ☐ No

Resides with Insured Individuals? ☐ Yes ☐ No	Married? ☐ Yes ☐ No	Sex ☐ Male ☐ Female

Registration/Permit No. Date Issued:	Issued by:

Dates of Confinement Admitted on: _____ at _____ AM/PM
Discharged on: _____ at _____ AM/PM

COMPLETE AND FINAL DIAGNOSIS (if injured, give dates and place of accident)

SHORT HISTORY OF ILLNESSES OF DISABILITY

Did disability or illness arise out of and in the course of the patient's employment? ☐ Yes ☐ No

If so, explain briefly

Is disability due to pregnancy? ☐ Yes ☐ No	If yes, give an approximate date of the first day of last menstruation

COMPLETE IF X-RAY OR LABORATORY SERVICES WERE PERFORMED (if with previous, please indicate also)

Type of Examination	Date	When Performed	Fee Charged	Findings

Previous consultation/treatment as out/inpatient prior to this confinement	PLACE	DATES	DIAGNOSIS
	Office		
	Home		
	Hospital		

TO BE COMPLETED IF SURGERY WAS PERFORMED: Nature of Surgical Operation/Obstetrical procedure performed
ICD CODE: _____

Date Performed	Where Performed	If performed in the hospital, check whether as ☐ Inpatient ☐ Outpatient

Name of Surgeon	Fees Charged:
Name of Anesthesiologist	Fees Charged:

OTHER DOCTORS WHO ATTENDED TO YOUR PATIENT:

NAME	SPECIALTY	PROCEDURES	FEES	DATE OF ATTENDANCE
1.				
2.				
3.				

The patient has been continuously disabled (unable to work)	FROM	TO

When should your patient be able to work?

REMARKS

I HEREBY CERTIFY that the preceding answers have been taken from the medical/hospital records of the above-named patient. They are full, complete, correct, and true.

I am a graduate of _____ in the year _____.

_____ Name of Attending Physician (Please Print)

_____ Signature of Attending Physician

Address _____

Date Signed: _____

Telephone No. _____

License No. _____

IMPORTANT NOTICE

"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."

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