



CLAIMANT'S STATEMENT OF ACCIDENT

(Accident Claim Form No. 1)

IMPORTANT

1. This form is released to the Claimant on receipt of notice of an Accident and ITS RELEASE IS NOT AN ADMISSION OF CLAIM NOR A WAIVER OF THE COMPANY'S RIGHTS AND DEFENSES UNDER THE POLICY AND ANY SUPPLEMENTARY CONTRACT THERETO. Accomplish this form and return it to the Company together with an accomplished Certificate of Attending Physician (Accident Claim Form No. 2).
2. No claim shall be accepted unless...the Certificate of Attending Physician is accomplished, at the expense of the Insured/Owner, by a duly qualified and registered Medical Practitioner and submitted to the Company.

DATA ON			
INSURED	HIS POLICY		
1. Name of Insured _____	Policy No. _____		
2. Insured's Present Address _____	Date of Issue _____		
3. _____	Date of Last Premium Paid _____		
4. Date of Birth _____	Payment Made To _____		
5. Present Occupation (if more than one, state all) _____	OTHER POLICIES WITH US OR OTHER INSURANCE CO.		
	Policy No.	Name of Insurance Co.	Amount
6. Employer's Address _____			
7. Nature of Business _____			

DATA ON THE ACCIDENT	
(Please write the answer after each question, leaving no space blank)	
1. (a) When did the accident occur?	1. (a) Time Month Day Year
(b) Where did it occur? (If a vehicular accident, please state the name of street or highway where accident occurred).	(b)
(c) How did it occur? Describe fully but briefly.	(c)
(d) Is the Insured right-handed or left-handed?	(d)
2. (a) What was the Insured doing at the time of the accident?	2. (a)
(b) If an employee, was he doing his duties as such when the accident happened? If "yes" please give full particulars	(b)
3. In case of vehicular accident: (a) Was Insured then a passenger in a vehicle public or otherwise? (State which) (b) If he was, please give type of vehicle, its full plate number and year of registration, xeroxed copy of Insured's driving license (plasticized) and at least renewal receipt of payment.	3. (a) (b) Type _____ Plate No. _____ Registration Yr. _____
4. (a) Was a police or constabulary investigation made of the accident? NOTE WELL: If answer to 4(a) "Yes", it is important, to avoid delay in processing your claim, to send along with this form certified true copy of the investigation report and copy(ies) of statement(s) of witness(es). If "No" explain why no such investigation was made.	4. (a)
5. What is the nature and extent of injuries? (If to arm or leg, state if right or left)	5.
6. (a) Give the name and address of the Physician who first attended the Insured when he met the accident	6. (a) Name: _____, M.D. Address: _____ Date of Attendance: From: _____ To: _____ Mo. Day Year Mo. Day Year
(b) Did Insured go to him or did he come to the Insured?	(b)

(c) Names and addresses of other physicians, if any, who at one time or another, had attended or subsequently attended the Insured in connection with this accident, or other previous illness, diseases or injury.	(c) Date on Consultation & Treatments						Dates					
	Nature of Illness/Injury	Name(s) of Attending Physician(s)	Address(es) of Attending Physician(s)	From			To					
				M	D	Y	M	D	Y			
(d) Who is Insured's Family Physician?	(d) Name Of Family Physician _____ Address _____											
7. Names and addresses of witnesses to accident?	7. Names						Addresses					
	(a)											
	(b)											
8. If Insured is expected to be necessarily and entirely confined by physician's orders as a direct result of injuries sustained, state place and date. (IMPORTANT: IF HOSPITALIZED, PLEASE ATTACH OFFICIAL STATEMENT OF HOSPITAL ACCOUNTS AND RECEIPTS OF PAYMENT)	8. Place of Confinement	Name of Hospital	Dates									
			From			To						
				M	D	Y	M	D	Y			
	Hospital _____											
Hospital _____												
9. If no longer confined but still receiving treatment, please state : (a) Where the Insured is being treated; (b) By whom treated (c) What treatments he is receiving	9. (a)											
	(b) Name _____, M.D. Address _____											
	(c)											
10. (a) At present, is Insured fully recovered? (b) If still disabled, state how long he is expected to be so.	10. (a)	Duration										
		From			To							
				M	D	Y	M	D	Y			
Partial Disability												
Total Disability												
11. (a) If answer to Question 10(a) is "Yes", give date Insured returned to work (b) Nature of Duties performed on return to work?	11. (a)	Duration										
		From			To							
				M	D	Y	M	D	Y			
Some Duties												
Substantially all Duties												

DECLARATION

I hereby declare that I am the person referred to in the foregoing particulars, that I have received the injuries described above by violent, accidental, external and visible means. And I do further declare that I have always been uniformly sober and temperate in my habits and that I was in no way under the influence of intoxicating liquors or drugs when the accident occurred, and that I have not abstained from business or work either totally or partially, longer than absolutely necessary in consequence of the said injuries; and that such injuries are the sole and direct cause of my disablement or loss.

I do hereby warrant the truth of the foregoing statements in every respect; and I agree that if I have made, or in any further declaration the Company may require of me in respect of the said accident shall make, any false or fraudulent statement or any suppression, concealment, or untrue averment, whatever, the Policy shall be void as against the Company, and my right to compensation absolutely forfeited.

I hereby claim indemnity as provided under my policy for the inquiries and disability above.

Dated at _____ on _____ day of _____ 200__

Witness's Name in Print _____
Signature _____
Occupation _____
Address _____

Signature of Insured/Claimant over printed name
(If the Insured cannot sign this form, it should be signed by a near relative or any other responsible person in charge of the Insured during his disablement)
Address _____
Telephone / Cellphone no. _____
Email _____

WAIVER AND AUTHORIZATION TO FURNISH MEDICAL INFORMATION

I EXPRESSLY WAIVE on my behalf and of any person who shall have any interest in, or may file a claim for indemnity under my Policy all provisions of law forbidding any physician, hospital official, or employee or any organization, entity or person who has heretofore attended or examined me, or who may hereafter attend or examine me, or who has been consulted by me, from disclosing any knowledge or information thereby acquired and from testifying with reference thereto.

FURTHER, I EXPRESSLY AUTHORIZE any such person, physician, hospital official, employee, organization or entity that has any record or knowledge of my health and/or that of _____ to give to the Philippine American Life and General Insurance Company any and all information about any hospitalization, consultation, treatment, or, any other medical advice or examination. A photocopy of this waiver and authorization shall be valid as the original.

Signed at _____ on _____ day of _____ 200__

Signature of Witness over printed name

Signature of Insured over printed name
Residence Certificate No. _____
Issued at _____ on _____

Address