

PROOFS OF HOSPITALIZATION

Submitted to

The Philippine American Life and General Insurance Company

THIS SECTION TO BE COMPLETED BY CLAIMANT. SUBMIT THIS FORM WITH ITEMIZED DOCTOR'S AND HOSPITAL'S BILLS. To avoid unnecessary delay in processing your claim, answer fully each question.

I hereby apply for benefits under my Policy No. _____ for medical/ surgical expenses incurred.

1. Name of Insured _____
a. Single Married Widowed
Divorced Male Female
Occupation _____

2. Date of birth _____ at _____
Month Day Year Age

3. Does ailment result from occupation of Insured?
Yes No

4. Describe nature ailment _____

5. Is ailment due to injury? Yes No
If "Yes", tell
When it happened _____ at _____
Month Day Year AM/PM

Where it happened _____
How it happened _____

6. If illness, when did it begin?

Month Day Year

7. Name and address of physician FIRST consulted?

8. Give date of FIRST visit _____
Month Day Year

8. Give name and address of your physician and all other physicians treating you for this ailment

10. Were you PREVIOUSLY confined in a hospital for this ailment? Yes No
If "Yes", give
Name of Hospital _____
Date Admitted _____
Month Day Year

11. Do you have any other hospitalization insurance in force with other insurance companies? Yes No
If "Yes" give
Date of effectivity _____
Name of Insurance Company _____

DO NOT FORGET TO ATTACH ITEMIZED BILLS

I HEREBY CERTIFY that the foregoing answers are true and correct to the best of my knowledge and HEREBY AUTHORIZE all doctors or other persons who treated me and all hospitals or other institutions to furnish full information (including full copies of their records) regarding this claim.

I further agree that the furnishing of this form, or of any other forms supplement thereto, by The Philippine American Life Insurance Company shall not constitute nor be considered an admission that there was any insurance in force on the life of the Insured, nor any waiver of any of its rights to defense.

Date: _____

Address: _____

SIGNATURE OF INSURED
Tel/ Cellphone# _____
Email: _____

THIS SECTION TO BE COMPLETED BY THE EMPLOYER:

12. Was claimant employed at the time disability began? Yes No If "Yes", in what capacity was he employed? _____

13. Did injury or illness for which claim is being made arise out of or in the course of occupational employment for wages or profit? Yes No

14. Has claim been made for Workmen's Compensation benefits for this disability? Yes No
If "Yes", is he entitled to such benefits? Yes No

MONTH DAY YEAR TIME
A.M.
P.M.

15. Last full day worked.

16. When did employee return to work?

A.M.
P.M.

17. If not back at work, when do you expect him/her to return?

A.M.
P.M.

Signature of Employer

Position Title: _____

Name of Firm: _____

THIS SECTION TO BE COMPLETED BY THE ATTENDING PHYSICIAN

18. Patient's name _____ Age _____ Sex _____

19. Give your complete diagnosis:

a. Tentative _____

b. Final _____

List of all complications and contributory causes _____

20. If surgery was performed, describe operation _____

Where and when was surgery performed? _____ Date _____
Month Day Year

Surgical Fee only (Exclude fees for medical calls, anesthesia, etc.) ₱ _____

21. List each date you _____ at home _____ Total _____ calls @ P _____

attended patient. _____ at hospital _____ Total _____ calls @ P _____

_____ at office _____ Total _____ calls @ P _____

22. Was patient hospitalized? Yes No Name of Hospital _____

Date of admission _____ at _____ o'clock _____
Month Day Year A.M. P.M.

Date of discharge _____ at _____ o'clock _____
Month Day Year A.M. P.M.

23. In your opinion, when did basic cause of condition first originate? _____
Month Day Year

24. In your knowledge, has patient been PREVIOUSLY confined in a hospital for this condition or for a condition due the same or related cause or causes? Yes No

If answer is "Yes", please complete:

Name of Hospital	Date of Confinement	Diagnosis
_____	_____	_____
_____	_____	_____
_____	_____	_____

25. In your opinion, is the condition due to injury or illness arising out of employment? Yes No
If answer is "Yes", please explain in full: _____

26. Has this disability been serious enough to prevent the patient from working? Yes No
If answer is "Yes", please answer the following:

	MONTH	DAY	YEAR	TIME
When was patient first unable to work?	_____	_____	_____	_____ A.M. P.M.
If not now prevented from working, on what Date could patient have returned to work?	_____	_____	_____	_____ A.M. P.M.
If not able to work now, on what date will Patient probably be able to work?	_____	_____	_____	_____ A.M. P.M.

Date _____, _____ Physician's Signature: _____ M.D.

Address: _____ Physician's Name (in print) _____

REMARKS _____