**CLAIM NOTIFICATION FORM**

**ACCIDENT/SICKNESS/TRAVEL RELATED**

**Directions:** Please answer this application form as truthfully as possible. All sections must be completed using **BLUE** ball pen or sign pen. Please use block letters. Application forms without the appropriate signatures and dates will be returned.

**I. POLICY HOLDER &/OR CLAIMANT**

|  |  |  |
| --- | --- | --- |
| POLICY NO: | | |
| Surname First Name Middle Name | | |
| Address: | | |
| Company/Employer’s Name: | | |
| Tel. No.: | Mobile No.: | E-mail Address: |
| Date of Birth (dd/mm/yy): | Age: | Gender: ☐ Male ☐ Female |

**II. NATURE OF CLAIM**

☐ ACCIDENT

|  |
| --- |
| Is the condition accident-related? ☐ Yes ☐ No  If yes: When did the accident happen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ At around what time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What was the cause of the accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Details of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

☐ SICKNESS/CONFINEMENT

|  |  |
| --- | --- |
| Date: | Time : |
| Medical Findings/Diagnosis: | |

☐ OTHER TRAVEL RELATED CLAIM

|  |  |
| --- | --- |
| ☐ Loss of Baggage ☐ Cancellation & Curtailment ☐ Personal Liability ☐ Emergency Repatriation  ☐ Delayed Baggage ☐ Missed Travel Connection ☐ Hijack ☐ Emergency Evacuation  ☐ Loss of Passport ☐ Delayed Departure ☐ Rental Vehicle Expense Cover ☐ Repatriation of Mortal Remains  ☐ Loss of Documents or Samples ☐ Missed Departure ☐ Additional Cost or Rental Car ☐ Hospital Benefit | |
| Travel Period : | Place and Date of incident: |
| Details of Incident: | |

**III.AUTHORITY AND DECLARATION STATEMENTS**

**Pursuant to IC Circular Letter No. 50-2016, Section 5: Fraud Warning**

“Section 251 of the lnsurance 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”.

**Data Privacy**

Pursuant to the foregoing Claim, I consent to the collection, use, processing and transfer of my personal data as described in this paragraph. I understand that the Company and/or its related companies hold certain personal information about me (including my name, address and telephone number, date of birth, social security number, tax identification number, etc.) for the purpose of processing my/ the Claim. I also understand that the Company may transfer this Data amongst its related companies as necessary for the purpose of processing, administering and managing my/ the Claim, and that the Company may also transfer this Data to any third parties assisting the Company in the processing, administration and management of the Claim. I authorize them to receive, possess, use, retain and transfer the Data, in electronic or other form, for these purposes. I also understand that I may, at any time, review the Data, require any necessary changes to the Data or withdraw my consent in writing by contacting the Company. I further understand that withdrawing my consent may substantially affect my ability to further process and collect on my/ the Claim.

**Declaration**

I hereby declare that I am claiming compensation under the above policy in respect thereof. I hereby warrant that the above statements and facts are true and that I have not withheld from the Company any material information in connection with this claim.

|  |  |  |
| --- | --- | --- |
| Signature over Printed **Name of Claimant or of Policy Holder** (if Claimant is Minor)  or the Beneficiary (if the Claimant/Policy Holder is incapacitated by illness) |  | Date |

Note: For accidental death claims, or for medical claims leading to death, the signatory of this form should be the Claimant’s Beneficiary.

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*page 3 of 4*

**REMINDER TO CLAIMANT:**

**REMINDER TO PATIENT:**

**Please refer to page 4 (Claims Checklist) for other documents required in filing a claim.**

**Please refer to back portion (Claims Reimbursement Checklist) for other documents required in filing a claim.**

**TO BE COMPLETED BY THE MAIN ATTENDING PHYSICIAN/SURGEON ONLY.**

|  |
| --- |
| 1. Admitted FROM: TO: |
| 2. Complete diagnosis/es of medical condition(s): Month and year when symptoms first appeared:  a.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  b. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3. Reason for admission: |
| 4. When did the patient first consult you on his/her condition? |
| 5. If it is a complication, when did the symptoms of its cause start? |
| 6. Did the patient’s condition require surgery? ☐ Yes ☐ No  If yes, please state: Name of surgical procedure involved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 7. Is the condition accident-related? ☐ Yes ☐ No  If yes: When did the accident happen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What was the nature of the accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 8. Is the illness or injury related to the patient’s employment? ☐ Yes ☐ No  If yes, state reason(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 9. Maintenance medication prior to first consult: |
| 10. What was your medical management? |
| 11. Please state the date when the patient can resume (a) Light Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,20\_\_\_  (b) His usual occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , 20\_\_\_\_\_ |

**TOTAL DISABLEMENT[[1]](#footnote-1)**

I FURTHER CERTIFY that he has been wholly unable to leaves his (Insert “Bed”, “Bedroom”, “House”) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as mentioned below and has been totally disabled by the above Accidental Injuries from the \_\_\_\_\_\_\_\_\_\_\_\_\_ day of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20 \_\_ and that he is likely to be disabled for \_\_\_\_\_\_\_\_\_\_\_ from the present time.

**PARTIAL DISABLEMENT[[2]](#footnote-2)**

I FURTHER CERTIFY that he has been partially disabled by the above Accidental injuries from the \_\_\_\_\_\_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20 \_\_\_ to the \_\_\_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20 \_\_\_\_\_\_and that he is likely to be so disabled for \_\_\_\_\_\_\_\_\_\_\_\_\_ from the present time.

***Pursuant to IC Circular Letter No. 50-2016, Section 5: 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.”*

***I declare that the above information is in all respect true and complete to the best of my knowledge and belief.***

***Data Privacy****. Pursuant to the foregoing Claim, I consent to the collection, use, processing and transfer of my personal data as described in this paragraph. I understand that the Company and/or its related companies hold certain personal information about me (including my name, address and telephone number, date of birth, social security number, tax identification number, etc.) for the purpose of processing my/ the Claim. I also understand that the Company may transfer this Data amongst its related companies as necessary for the purpose of processing, administering and managing my/ the Claim, and that the Company may also transfer this Data to any third parties assisting the Company in the processing, administration and management of the Claim. I authorize them to receive, possess, use, retain and transfer the Data, in electronic or other form, for these purposes. I also understand that I may, at any time, review the Data, require any necessary changes to the Data or withdraw my consent in writing by contacting the Company. I further understand that withdrawing my consent may substantially affect my ability to further process and collect on my/ the Claim.*

License No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Name and Signature of **Attending Physician**/Date Signed |

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **CLAIMS CHECKLIST** | |
| **ACCIDENT/SICKNESS RELATED :**  **STANDARD REQUIREMENTS:**  ☐ Duly-accomplished Notification of Claim Form  ☐ Duly-accomplished Attending Physician Report  ☐ Copy of police report  ☐ Detailed Incident Report or Affidavit  ☐ Copy of Claimant’s valid ID/Company ID  ☐ For Corporate loss payee, Board Resolution or Secretary’s Certificate  for the authorized signatory of the Company (waived for claims  Php100,000 and below)  **In the event of Death or Disablement**  ☐ Amputation Chart accomplished by physician (for permanent disability)  ☐ Post Mortem Report or Medico Legal Report or Autopsy Report  ☐ Death Certificate issued by PSA \*  ☐ Marriage Certificate issued by PSA (if beneficiary is spouse)  ☐ Birth Certificate issued by PSA (if beneficiary is Insured’s children)  ☐ Insured’s Birth Certificate issued by PSA (if beneficiary/ies are parents)  ☐ Original Copy of Official Receipts for Burial Expenses  Note: \*PSA - Philippine Statistics Authority  **For Medical Expense Reimbursement, Hospital Cash Benefits**  ☐ Medical Report /Clinical Abstract  ☐ Original Copy of Official Receipts, Charge Slips & Statement of Account  ☐ Copy of the drug prescription from the attending physician  ☐ Copy of request for laboratory, X-ray, other diagnostic exams and therapeutic services  ☐ Copy of results of laboratory, X-ray, other diagnostic exams and therapeutic services  **For Hospital Confinement Income Protection**  ☐ Medical Certificate of Confinement with seal of the hospital  ☐ Discharge Instruction Slip/Clinical Abstract  ☐ Hospital Statement of Account (original/certified true copy)  Note: For enrolled dependents, please attached copy of principal insured company/valid ID and other documents showing relationship  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DISCLAIMER**:** Kindly note that the submission of the above-mentioned documents does not guarantee approval of your claim. Your claim will be reviewed and evaluated based on available documents submitted and subject to the limits and the terms and conditions of your existing Policy.  ***BPI MS reserves the right to request for additional documents as deemed necessary.***  **DATA PRIVACY UNDERTAKING**: The personal information collected through the Accident Claim Forms A and B shall be used, processed, and disclosed for purposes of evaluating the policy holder’s claim with BPI/MS Insurance Corporation and in accordance with the Data Privacy Act of 2012, its implementing rules and regulations, and the BPI/MS Data Privacy Statement found in www.bpims.com.  NOTE**:** If the patient has other health insurance, a certification of Claim Settlement/Payment from other health insurance must be attached to this Notification of Claim Form along with all applicable requirements listed herein.  **BPI MS Insurance Corporation**  11th, 14th, 16th & 18th Floors, 6811 BPI-Philam Life Makati,  Ayala Avenue, Salcedo Village Bel-Air, City of Makati  NCR, Forth District, Philippines 1209  Email: www.bpims.com | **TRAVEL RELATED :**  **STANDARD REQUIREMENTS:**  ☐ Duly-accomplished Notification of Claim Form  ☐ Police Report ☐ Plane ticket/boarding pass  ☐ Detailed Incident Report or Affidavit  ☐ Photocopy of passport together with stamp of entry and exit during the travel  **For Medical Expense Reimbursement, Hospital Cash Benefits**  ☐ Medical Report /Clinical Abstract  ☐ Original Copy of Official Receipts, Charge Slips & Statement of Account  ☐ Copy of the drug prescription from the attending physician  ☐ Copy of request for laboratory, X-ray, other diagnostic exams and therapeutic services  ☐ Copy of results of laboratory, X-ray, other diagnostic exams and therapeutic services  **For Loss of Passport**  ☐ Billings, Invoices ☐ Official Receipts  **For Loss of Baggage, including Delays:**  ☐ Airline Irregularity Report or Certification from the Airline/Carrier  ☐ Proof of Acknowledgment of Baggage  ☐ Official Receipts and/or Invoices as proofs of immediate purchases such as clothing and toiletries  ☐ Actual replacement or repair cost of baggage  ☐ Picture of damage baggage  **For Trip Cancellation/Curtailment, Delayed Departure**  ☐ Certification from the Airline/Carrier stating scheduled departure time, actual departure time and the reason for the cancellation or delay of flight  ☐ Non-refundable expenses such as airline tickets, Official Receipts and/or Invoices for irrevocable deposits and advance payments for hotel accommodations (for Trip Cancellations)  ☐ Official Receipts and/or Invoices for restaurant meals, refreshment (for Flight delays)  **For Missed Travel Connections, Missed Departure**  ☐ Proof of expenses for the additional/alternative travel and accommodation costs in the arrangement of alternative travel, such as Official Receipts and/or Invoices  **For Rental Vehicle Excess of Cover**  ☐ Rental Agreement/Contract  ☐ Accident Report ☐ Police Report ☐ Driver’s License  ☐ Estimate on the damage vehicle (as caused by collision or theft while in custody  **For Additional Cost of Rental Car Return**  ☐ Rental Agreement/Contract  ☐ Certification from Car Rental Co. ☐ Invoice or Statement of Acct  **For Personal Liability**  ☐ Claim or Demand letter from the third party or beneficiary  ☐ Medical/clinical report ☐ Affidavit  ☐ Statement of Witness/es ☐ Original copies of Official Receipts,  Charge Slip & Statement of Account  **For Hijack, Extension of Period of Journey, Emergency Medical Repatriation, Transportation of Mortal Remains**  ☐ Proofs of billings or expenses such as Statement of Accounts/Official Receipts  **For Emergency Telephone Expenses**  ☐ Statement of Account and proofs of telephone bill payment |

1. Total Disablement arises when the Claimant is rendered completely incapable of attending to any part of his ordinary profession, business or occupation. [↑](#footnote-ref-1)
2. Partial Disablement arises when the Claimant is so little injured, or has so far recovered from injuries as to be capable of attending to some portion of his ordinary profession, business or occupation. [↑](#footnote-ref-2)