

The best way to show your Love

GROUP HOSPITALIZATION INSURANCE BENEFIT CLAIM FORM

PART 1 - TO BE COMPLETED BY THE INSURED CLAIMANT 1. Name of Claimant: Date of Birth:: Present Address: Certificate No. 3. If claim is made for Dependent: Name: Relationship:	IMP	ORTANT: This form shall be accompanied by the itemized bills, charge tickets and offi	ne original copies of Hospi cial receipts.	ital's and Doctor	's Statement of Ac	count and/o
1. Name of Claimant: Present Occupation: 2. Present Address: Certificate No. 3. If claim is made for Dependent: Name:	PAR	T I – TO BE COMPLETED BY THE INSURED	CLAIMANT	• x 	signification	
2 Present Address: Telephone No. 3. If claim is made for Dependent: Name:	1.	Name of Claimant:			ation:	
Relationship:	2.	Present Address:	check whether o theory	2 m 2		1.4.521
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 happened? Was the insured person at work when the accident happened? Ves No As the how it happened? S.a. Was insured person hospitalized? Yes No Name of Attending Physician: Is insured person entitled to receive compensation under the Labor Laws? Yes No If Yes, state with what insurance company or under what employer's prepayment plan? Thereby certify that the foregoing statements, including any accompanying statements are, to the best of my knowledge and belief, rule, correct and complete. I hereby authorize any physician to furnish and disclose all known facts concerning this disability to Manila Bankers Life Insurance Corporation, or to its authorized representative. Date: Claimant's Signature PART II - TO BE COMPLETED BY THE AUTHORIZED OFFICER OF THE POLICYHOLDER/EMPLOYER NAME OF POLICYHOLDER: It Employee is the sick person a.t AM PM Date resumes to work: at AM PM Did disability occur due to occupational cause or in the course of employment? Yes No	3.	If claim is made for Dependent:	Name:			
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	Patient's Name:		an a	Age:	·	Sex:
2.	Did this sickness/injury occur	red during the course of his e	mployment? [Yes] No	
3.	Was patient hospitalized?		in the second		•	
	a. Name of Hospital	<u> </u>	<u>a da ana an</u> a amin'ny faritr'o ana amin'ny faritr'o amin'ny faritr			
	b. Is this hospital/clinic regis		∐ Yes	∐ .No		
	c. If not, does it have a perm	a the Tool of the test of the Effective	 A state of the state 	Yes	∐ No	
	d. Registration/Permit No		ed:	Issued b	y:	
4.	History of Illness or Injury in	details:				
FIN	JAL DIAGNOSIS					
5.	Date Admitted:	at AM/PM	Date Discharge	ed:		at AM
6.	List X-Ray, Laboratory or oth What	ner services done: <u>Where</u>	When	са на Марија на села, на редно на алексија 	Amount	Findings
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8.		PLACE Office Home	nistered		FEES	CHARGED
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8.	Give dates of treatment	PLACE Office Home Hospital	nistered		FEES	CHARGED
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