MANILA BANKERS LIFE INSURANCE CORPORATION

The best way to show your Love

GROUP HOSPITALIZATION INSURANCE BENEFIT CLAIM FORM

IMPORTANT: This form shall be accompanied by the original copies of Hospital's and Doctor's Statement of Account and/or itemized bills, charge tickets and official receipts.

PART I – TO BE COMPLETED BY THE INSURED CLAIMANT

1. Name of Claimant: | Date of Birth: / Present Occupation:

2. Present Address: | Certificate No. / Telephone No.

3. If claim is made for Dependent: Name: _____

Relationship: _____ Date of Birth: _____ Sex/Status _____

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 happen? _____

c. Was the insured person at work when the accident happened? ☐ Yes ☐ No

d. State how it happened? _____

5.a. Was insured person hospitalized? ☐ Yes ☐ No Name of Hospital

b. Name of Attending Physician:

6. Is insured person entitled to receive compensation under the Labor Laws? ☐ Yes ☐ No

a. Is he claiming benefits under another health insurance? ☐ Yes ☐ No

b. If Yes, state with what insurance company or under what employer's prepayment plan?

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 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:

1. Claim is made for: ☐ Employee (Named Above) ☐ Spouse ☐ Child

2. If Employee is the sick person

a. First day unable to work: _____ at _____ AM _____ PM

b. Date resumes to work: _____ at _____ AM _____ PM

3. Did disability occur due to occupational cause or in the course of employment? ☐ Yes ☐ No

4. Has Claim been or will be filed under the Labor Laws? ☐ Yes ☐ No

5. Has there been any previous claim filed for this person's confinement? ☐ Yes ☐ No

If yes, give approximate date:

REMARKS:

DATE _____ _____ _____

Signature over Printed Name Title/Position

PART III - THIS IS TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. Patient's Name: | Age: _____ | Sex: _____

2. Did this sickness/injury occured during the course of his employment? ☐ Yes ☐ No

3. Was patient hospitalized? ☐ Yes ☐ No

   a. Name of Hospital _____ Address: _____

   b. Is this hospital/clinic registered with the Bureau of Medical Services? ☐ Yes ☐ No

   c. If not, does it have a permit to operate as such to admit in-patient? ☐ Yes ☐ No

   d. Registration/Permit No. _____ Date Issued: _____ Issued by: _____

4. History of Illness or Injury in details:

FINAL DIAGNOSIS

5. Date Admitted: _____ at _____ AM/PM Date Discharged: _____ at _____ AM/PM

6. List X-Ray, Laboratory or other services done:

What	Where	When	Amount	Findings

7. Drugs and Medicines administered in the hospital/clinic:

Name of Drug	Dosage or No. of Time Administered	Quantity	Unit Cost

8. Give dates of treatment and medical fees charged

PLACE	DATES	FEES CHARGED	
		Per Call	Total
Office			
Home			
Hospital			

9. Nature of Surgical or Obstetrical Procedure, if any:

   a. Date Performed: If performed in hospital check whether as ☐ IN ☐ OUT ☐ PATIENT

   b. Performed by: Amount Charged:

   c. Name of Anesthesiologist: Amount Charged:

10. a. The patient has been continuously disabled: FROM _____ TO _____

    b. When should patient be able to return to work?

Dated at _____ this _____ day of _____ 19____

_____ NAME OF ATTENDING PHYSICIAN (IN PRINT)

_____ SIGNATURE

ADDRESS: _____ TELEPHONE NO. _____

NOTE: PLEASE RETURN THIS FORM TO THE INSURED

FORM NO. GCL-020-1 (Revised ___)