Accident / Sickness Insurance Claim Form

This form must be completed truthfully and accurately
The list of documents required is not exhaustive and we reserve our right to request from you any additional information / documentation, as necessary. The submission of an incomplete form or insufficient information or supporting documents may delay the processing or result in the denial of your claim.
The completed form should be returned to us together with all supporting documents as soon as possible at the following address:

Claims Department

AIG Philippines Insurance, Inc. (formerly known as Chartis Philippines Insurance, Inc.)

30th Floor, Philam Life Tower 8767 Paseo De
Roxas Street 1226 Makati City, Philippines

Filing by the assured / claimant of this claim form is for purposes of claim evaluation only and does not constitute admission of liability by AIG Philippines Insurance Inc. (formerly known as Chartis Philippines Insurance, Inc.) We reserve the right for additional document(s), if need be.

GENERAL REQUIREMENTS

Basic documents required

- Duly accomplished and signed accident/sickness insurance claim form;
- Copy of certificate of insurance
- Proof of premium payment
- Photocopy of valid ID

Additional required documents for

Accident Death Claim: (Original or Certified True Copies of)

- ☐ Attending physician's report
- ☐ Police investigation report of statement of witness(es);
- ☐ Birth Certificate
- ☐ Death Certificate
- ☐ Autopsy Report
- ☐ Marriage Contract

Accident / Sickness Hospitalization / Dismemberment claim:

- ☐ Attending physician's report
- ☐ Police investigation report of statement of witness(es);
- ☐ Hospital statement of account
- ☐ Original copy of medical bills and receipts
- ☐ Prescriptions
- ☐ Medical records (history / diagnosis

GENERAL INFORMATION ON ASSURED	
NAME OF ASSURED	Last Name First Name Middle Name
Type of Policy / Policy No.	
GENERAL INFORMATION ON CLAIMANT	
CLAIMANT'S NAME	Last Name First Name Middle Name
Nationality	
Social Security No. (for U.S. Citizen)	
CLAIMANT DATE OF BIRTH	(mm/dd/yyyy) |_|_| / |_|_|/ |_|_|_|_|
RELATIONSHIP TO ASSURED	
GENDER	☐ MALE ☐ FEMALE
AIG Employee?	☐ YES ☐ NO
RESIDENCE ADDRESS	
Street	
Province / City	
Zip Code	
Telephone No.	
Fax No.	
E-MAIL ADDRESS	
BUSINESS ADDRESS	
Street	
Province / City	
Zip Code	
Telephone No.	
Fax No.	
E-MAIL ADDRESS	

DETAILS OF ACCIDENT / ILLNESS / INJURY	
DATE	(mm/dd/yyyy) |_|_| / |_|_|/ |_|_|_|_|
PLACE	
NATURE OF ACCIDENT / ILLNESS / INJURY	
DESCRIPTION OF ACCIDENT / ILLNESS / INJURY – HOW DID IT OCCUR? |	
PLACE(S) CONFINED HOUSE HOSPITAL	FROM (mm/dd/yyyy) |_|_| / |_|_|/ |_|_|_|_| TO |_|_| / |_|_|/ |_|_|_|_| FROM (mm/dd/yyyy) |_|_| / |_|_|/ |_|_|_|_| TO |_|_| / |_|_|/ |_|_|_|_|
ATTENDING PHYSICIAN(S) NAME(S) ADDRESS(ES)/TEL. NO.:	
DO YOU HAVE ACCIDENT OR SICKNESS INSURANCE WITH ANY OTHER COMPANY?	☐ YES ☐ NO
IF YES, NAME OF CO-INSURER	

I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any of my illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A Photostatic copy of this authorization shall be considered as effective as the original.

By providing your Personal Information to AIG Philippines in connection with your claim [and signing below], you consent to the collection and processing (including the use and disclosure) of your Personal Information as described in this Privacy Policy available at www.aig.com.ph or upon request. In particular you consent to the transfer of your Personal Information internationally. You agree that you will not provide Personal Information about any other individual without that person's permission.

Signature:

Name: Date:

ATTENDING PHYSICIAN REPORT

NAME OF PATIENT	Last Name First Name Middle Name
GENERAL INFORMATION ON CLAIMANT	
CLAIMANT'S NAME	Last Name First Name Middle Name
Nationality	
Social Security No. (for U.S. Citizen)	
CLAIMANT DATE OF BIRTH	(mm/dd/yyyy) |_|_| / |_|_|/ |_|_|_|_|
Gender	☐ MALE ☐ FEMALE
Age	
DATE OF CONSULTATION	
NATURE OF ILLNESS / INJURY	
CHIEF COMPLAINT	
FINAL DIAGNOSIS	
BRIEF HISTORY OF	
PRESENT ILLNESS	
COMPLICATIONS IF ANY	

** IS CONDITION DUE TO: FRACTURE / DISLOCATION? ☐ YES ☐ NO

If YES, Nature of fracture / dislocation is ☐ Complete ☐ Incomplete

☐ YES ☐ NO

If YES, Loss of sight is in ☐ Left eye ☐ Right eye ☐ Both eyes

Nature of sight loss is ☐ Entire & irrecoverable ☐ Partial & irrecoverable

Date of first appearance of symptoms/ accident (MM/DD/YYYY) _____

PREGNANCY ☐ YES ☐ NO

If YES, Date of first consultation (MM/DD/YYYY) _____

INJURY OR SICKNESS OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO

FULLY DESCRIBE NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE, IF ANY _____

PATIENT HOSPITALIZED? ☐ YES ☐ NO

HOSPITAL ADDRESS _____

DATE ADMITTED (MM/DD/YYYY) _____

DATE DISCHARGED (MM/DD/YYYY) _____

LAB EXAM RESULTS _____

MEDICATIONS GIVEN _____

_____

PRINTED NAME & SIGNATURE OF ATTENDING PHYSICIAN

ADDRES _____

LICENSE NO. _____

P.T.R. NO _____

ISSUED AT _____

ON (MM/DD/YYYY) _____

TIN NO. _____

DATE (MM/DD/YYYY) _____