MANILA BANKERS

LIFE AND GENERAL ASSURANCE CORP

The best way to show your Love

GROUP CLAIMS SECTION
GROUP ADMINISTRATION DEPARTMENT

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	FEES CHARGED 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 ___)