The Insular Life Assurance Company, Ltd.
Insular Life Corporate Centre, Insular Life Drive
Filinvest Corporate City, Alabang, 1781 Muntinlupa City
E-mail: headofc@insular.com.ph • Website: www.insularlife.com.ph
Tel.: (632) 582-1818 • Fax: (632) 771-1717 • TIN 000-464-124 Non-VAT

I-Heal

INSTRUCTIONS TO CLAIMANT:

(1) This form (I-Heal Claim Accident Form I) is to be used if disability is due to an accident and must be completed by the INSURED/POLICYHOLDER. (If not applicable, please write N/A in the space provided for.)

(2) The following must be submitted, along with this form:
(2.1) Hospital's Certification (I-Heal Claim Form II);
(2.2) Physician's Statement (I-Heal Claim – Accident Form III);
(2.3) Surgeon's Certification (I-Heal Claim Form IV), if surgery was performed;
(2.4) All required documents indicated in the above-listed forms;
(2.5) Copy of the Police Report;
(2.6) Sworn Statement of Witness/es, if any;
(2.7) Newspaper Clippings, if any; and,
(2.8) All applicable documents indicated under Items 6 & 7 below.

(3) Submit to the Customer Care Unit of The Insular Life Assurance Company, Ltd. located at the above address or to any Insular Life Office.

INSURED'S STATEMENT OF CLAIM
(I-HEAL CLAIM ACCIDENT FORM I)

To: The Insular Life Assurance Company, Ltd.

I hereby submit this claim under the policy or policies of this Company, numbered as follows: _____. All of the following answers and statements are true, complete, and correctly recorded.

I understand that:
1) Issuance of this form and other claim forms by the Company does not constitute an admission that there is any insurance in force.
2) Insular Life shall evaluate the reasonableness of amount of charges and expenses claimed and shall process the claim in accordance with the customary medical expenses and professional fees for the type of disability that I am filing, subject to the applicable policy contract provisions.

OTHER POLICIES OF INSURED WITH US OR WITH OTHER INSURANCE COMPANIES:

Policy Number	Name of Insurance Company	Amount of Insurance

INFORMATION ON THE INSURED

Given Name: _____ Surname: _____ Suffix: _____

Mother's Maiden Name

Given Name: _____ Surname: _____

Date of Birth: _____ Place of Birth: _____

Occupation: _____ Gender: _____ Marital Status: _____

Present Address:

_____
House No. Street Barangay Town/Municipality

_____
City/Province Country Zip Code

Residence Tel No.	Office Tel. No.	Mobile No.	Email Address

INFORMATION ON THE POLICYHOLDER (if Insured is different from Policyholder)

Given Name: _____ Surname: _____ Suffix: _____

Date of Birth :_____ Gender:_____

Mother's Maiden Name

Given Name: _____ Surname: _____

INFORMATION ON THE ACCIDENT

1. Date and time of accident _____
Month Day Year Time

2. Place of Accident: _____
Name of Street/ Highway City or Municipality Province Country

3. Narrate completely how the injury was sustained: (Please use back page of this form if you need more space.)

_____

_____

_____

_____

4. Where were you before the accident? What were you doing before the accident happened? Who were with you before the accident?

_____

_____

_____

_____

5. If you are employed, were you at work at time of accident? If yes, give details:

_____

_____

_____

_____

6. Please answer if claim is due to a vehicular accident

6.a. During the accident, were you a passenger, driver or pedestrian? _____
6.b. If driving or riding a motorcycle, were you wearing a helmet? YES _____ NO _____
6.c. If driving or riding a vehicle, were you wearing a seatbelt? YES _____ NO _____
6.d. Please fill up the following:

If traveling by land
Route:
Name of Driver :
Vehicle type:
Plate Number:
Registration Year:
Please attach photocopies of Official Receipt, Certificate of Registration and your Driver's License, if you are the one driving.

If traveling by Plane or Ship
Name of Airline/Shipping Company
Office Address of Airline/Shipping Company:
Telephone Nos. E-mail address
Please attach a Certification from the Airline/Shipping Company stating that you are included in the list of passengers manifest.

7. Was a police investigation conducted on the accident? If yes, please submit certified true copy of the police investigation report and copy(ies) of statement(s) of witness(es). If "No", explain why such investigation was not made.

_____

_____

_____

_____

8. Names and addresses of witnesses to the accident:

Name of witness	Addresses /Contact Numbers

9. Give the names and addresses of the Physicians who attended to you for injuries sustained from the accident:

Name of Physician	Addresses of Hospital/Clinic	Date of Attendance					
		From			To		
		Mo.	Day	Year	Mo.	Day	Year

10. If confined in hospital, please provide history of confinement:

Name of Hospital	Address	Date of Confinement					
		From			To		
		Mo.	Day	Year	Mo.	Day	Year

11. If you are no longer confined but still receiving treatment, please provide:

a. Place of treatment: _____

Name of Physician _____ Contact Numbers: _____

Clinic Address_____

b. Kind of treatment/s: _____

INFORMATION ON YOUR PAST MEDICAL HISTORY (Please answer each question, if not applicable, write N/A)

1. Give names and addresses of other physicians or such person as a herb doctor (herbolaryo), if any, who had attended you for other previous illnesses or diseases or surgery.

Date of Consultations & Treatments			Dates					
Nature of Illness/injury	Name(s) of Attending Physician(s) or Herb Doctor	Address (es) of Attending Physician(s) or Herb Doctor	From			To		
			Mo.	Day	Year	Mo.	Day	Year

2. Names of your Family Physician

Name of Physician	Addresses /Contact Numbers

Signature of Insured: _____Date: _____

Signature of Policyholder: _____ Date: _____

Name and Signature of Witness: _____ Date: _____

Address of Witness: _____

SUBSCRIBED AND SWORN to before me this _____ day of _____20___, by the above claimant who exhibited to me his/her Govt. issued ID/Passport No. _____, issued at _____on _____.

Doc. No. _____
Page No. _____
Book No. _____
Series No. _____

NOTARY PUBLIC
My Commission expires on _____

AUTHORIZATION

To Whom It May Concern:

This authorizes the Insular Life Assurance, Co., Ltd. or its authorized representative to secure whatever information or record you may have regarding my medical history, accident, and hospital confinement. This authorization is being made in connection with my claim on the insurance policy issued by the said insurance company. I agree that a photocopy of this authorization shall be considered valid.

This authorization discharges you or any authorized member of your staff from any responsibility or obligation in connection with the release of such record or information.

Signature of Insured: _____ **Date:** _____

Name and Signature of Witness: _____ **Date:** _____