

**CLAIMS REPORT  
ACCIDENT & HEALTH INSURANCE**

**NOTICE TO INSURED / CLAIMANTS**

1. Accomplish Part A of this form by answering all question accurately and completely, placing "N.A." where not applicable and by checking the appropriate boxes.
2. Request your attending physician to accomplish Part B of this form, "Attending Physician's Statements".
3. Attach original or copy of documents cited hereunder. You will be notified in case additional documents are needed.
4. Forward this form with the pertinent documents to any office of Fortune General Insurance Corporation near your vicinity.

**REQUIREMENTS**

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| <p><b>A. ACCIDENTAL MEDICAL REIMBURSEMENT</b></p> <ol style="list-style-type: none"> <li>1. Police Report / Affidavit of the Claimant</li> <li>2. Medical Certificate, Bills &amp; Receipts</li> <li>3. Physician's Prescription (RX)</li> <li>4. Certificate of Insurance / Endorsement</li> </ol> <p><b>B. DISMEMBERMENT / DISABLEMENT</b></p> <ol style="list-style-type: none"> <li>1. Police Report *</li> <li>2. Notarized Affidavit of the Claimant **</li> <li>3. Operating Room Record</li> <li>4. Detailed Clinical Summary</li> </ol> <p><b>C. HOSPITAL INCOME BENEFIT</b></p> <ol style="list-style-type: none"> <li>1. Police Report *</li> <li>2. Notarized Affidavit of the Claimant **</li> <li>3. Hospital Bill</li> <li>4. Hospital Discharge Summary / Admitting History</li> <li>5. Certificate of Insurance / Endorsement</li> </ol> | <p><b>D. SURGICAL BENEFIT</b></p> <ol style="list-style-type: none"> <li>1. Hospital Bill</li> <li>2. Detailed Clinical Summary</li> <li>3. Operating Room Record</li> <li>4. Certificate of Insurance / Endorsement</li> </ol> <p><b>E. DEATH</b></p> <ol style="list-style-type: none"> <li>1. Death Certificate</li> <li>2. Police Report *</li> <li>3. Notarized Affidavit of the Claimant ***</li> <li>4. Proof of Relationship to Beneficiary</li> <li>5. Certificate of Insurance / Endorsement</li> </ol> <p>* If claim is accident related<br/>** If due to illness</p> <p>Note : Other Documents as may be needed, such as:</p> <ol style="list-style-type: none"> <li>1. Affidavit of Two Dis-Interested Person</li> <li>2. Certification</li> <li>3. Waiver of Rights</li> </ol> |
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**PART A – TO BE FILLED UP BY THE INSURED / CLAIMANT**

Name of Group, If group policy	Policy No.
Full Name of the Insured	Full Name of Claimant ( other than insured )
Address	Birthdate of Claimant
Relationship of Claimant to insured	Occupation
<p>a. Date injured or date of illness:    Month _____    Day _____    Year _____</p> <p>b. If injured, described in detail where and how the accident happened</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p>c. If due to illness, describe nature _____</p>	
<p>If due to illness, have you received medical treatment Or advice before this condition ? If Yes , Please give detail    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Hospital : _____    Physician : _____    Date : _____</p>	
<p>Indicate name and address of attending physician or surgeon :</p> <p>Name : _____    Address : _____</p>	
<p>If hospitalized</p> <p>Hospital Name : _____    Address : _____</p>	
<p>Period of hospital confinement :</p> <p>From : _____    To: _____</p>	

Privacy Consent Statement, I declare that all the information that I provide in this form are mine, true, correct, and updated. By submitting this Incident Report, I authorize and provide my explicit consent to FGEN's Data Processing, Profiling and Sharing provisions as required under Republic Act 10173 and other applicable laws and regulations. I also agree to FGEN's Privacy Policy.

\_\_\_\_\_  
Insured / Claimant's Signature / Date

### AUTHORIZATION

I hereby authorize my physician, hospital or any person who has attended or examined me to furnish Fortune General Insurance Corporation or its authorized representative, any of all information with regard to any illness or injury, medical history, consultation, prescription of treatment, copies of all hospital medical records. A photocopy of this authorization shall be valid as the original.

Signature of Insured / Claimant : \_\_\_\_\_ Date Signed ; \_\_\_\_\_

Address : \_\_\_\_\_ Tel. / Mobile No. \_\_\_\_\_

### PART B – ATTENDING PHYSICIAN'S STATEMENT

Patient's Name : \_\_\_\_\_ Age : \_\_\_\_\_ Sex : \_\_\_\_\_

Nature of illness or injury :

a. Chief Complain \_\_\_\_\_

b. Final Diagnosis \_\_\_\_\_

c. Brief history of present illness \_\_\_\_\_

d. Complication, if any \_\_\_\_\_

e. If fracture or dislocation occurred, state whether complete or incomplete \_\_\_\_\_

f. If loss of sight, check whether  Right Eye  Left Eye  Both Eye  
 Entire and Irrecoverable  Partial and Recoverable

When did the symptoms first appear or the incident happen? \_\_\_\_\_

Is the condition due to pregnancy?  Yes  No

When did the patient first consult you for this condition? \_\_\_\_\_

Nature of surgical or obstetrical procedure, if any (describe fully)  
\_\_\_\_\_  
\_\_\_\_\_

Was patient hospitalized?  Yes  No Date Admitted: \_\_\_\_\_ Date Discharged: \_\_\_\_\_

Name of Hospital: \_\_\_\_\_ Address: \_\_\_\_\_

How long the patient was or will be continuously / totally disabled (unable to work)? \_\_\_\_\_

Is the condition due to injury or sickness arising out of patients employment? \_\_\_\_\_

Attending Physician : \_\_\_\_\_

Signature : \_\_\_\_\_

License No. : \_\_\_\_\_

PTR No. : \_\_\_\_\_

Date : \_\_\_\_\_

### FRAUD WARNING

"Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under the contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim."