FORTUNE GENERAL INSURANCE CORPORATION

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

A. ACCIDENTAL MEDICAL REIMBURSEMENT
   1. Police Report / Affidavit of the Claimant
   2. Medical Certificate, Bills & Receipts
   3. Physician's Prescription (RX)
   4. Certificate of Insurance / Endorsement

B. DISMEMBERMENT / DISABLEMENT
   1. Police Report *
   2. Notarized Affidavit of the Claimant **
   3. Operating Room Record
   4. Detailed Clinical Summary

C. HOSPITAL INCOME BENEFIT
   1. Police Report *
   2. Notarized Affidavit of the Claimant **
   3. Hospital Bill
   4. Hospital Discharge Summary / Admitting History
   5. Certificate of Insurance / Endorsement

D. SURGICAL BENEFIT
   1. Hospital Bill
   2. Detailed Clinical Summary
   3. Operating Room Record
   4. Certificate of Insurance / Endorsement

E. DEATH
   1. Death Certificate
   2. Police Report *
   3. Notarized Affidavit of the Claimant ***
   4. Proof of Relationship to Beneficiary
   5. Certificate of Insurance / Endorsement

* If claim is accident related
** If due to illness

Note : Other Documents as may be needed, such as:
1. Affidavit of Two Dis-Interested Person
2. Certification
3. Waiver of Rights

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

a. Date injured or date of illness: Month _____ Day _____ Year _____

b. If injured, described in detail where and how the accident happened

_____

_____

_____

c. If due to illness, describe nature _____

If due to illness, have you received medical treatment
Or advice before this condition ? If Yes , Please give detail ☐ Yes ☐ No
Hospital : _____ Physician : _____ Date : _____

Indicate name and address of attending physician or surgeon :

Name : _____ Address : _____

If hospitalized
Hospital Name : _____ Address : _____

Period of hospital confinement :
From : _____ To: _____

☐ 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."