Allianz PNB LIFE INSURANCE

Policy No. ☐☐☐ ☐☐☐ ☐☐☐

## STATEMENT OF CLAIMANT FOR DISMEMBERMENT / HOSPITALIZATION / ACCIDENTAL MEDICAL REIMBURSEMENT

This form and the written notice of the accident and/or hospital confinement for which the claim may be based must be submitted within 30 days of commencement of such accident and/or confinement. No claim can be admitted unless the insured is confined in a licensed hospital and a medical certificate from a duly registered Medical Practitioner is furnished at the expense of the Insured.

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 be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent present or use the same, or to allow it to be presented in support of any claim.

### INFORMATION ON THE INSURED

Full Name _____

Date of birth _____ Nationality _____ Occupation _____

### DETAILS OF THE ACCIDENT

Date of accident _____ Place of accident _____

Cause of accident (please provide details) _____

_____

Describe the extent of the injury/ies in detail _____

_____

Diagnosis of the Attending Physician _____

Date of return or expected return to work _____

### DETAILS OF THE ILLNESS

Describe the nature and symptoms of your illness/disease _____

_____

Date the symptoms first occurred _____

Have you recovered from your illness/disease? _____

Have you had this condition or a similar one previously? Please provide details. _____

_____

### PHYSICIANS

| Physician's Name | Clinic/Hospital Affiliations | Contact Nos. |
|---|---|---|
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| | | |
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## PRESCRIBED MEDICINES &/OR TREATMENT

| Physician's Name, Address & Contact No. | Nature of Injury/Treatment | Prescribed Medicines &/or Treatment |
|---|---|---|
| | | |
| | | |

## DETAILS OF CONSULTATION/S & HOSPITAL CONFINEMENT/S

| Name, Address & Contact No. of Hospital, Clinic or Institution | Attending Physician (Please include Surgeons, if any) | Inclusive Date of Consultation/s and/or Confinement | Nature of Injuries | Procedure/ Operation/s Done |
|---|---|---|---|---|
| | | | | |
| | | | | |

Do you have similar coverages with any other company? _____Yes / _____No. If yes, please give details:
Company Name:_____ Policy No. _____ Benefit Type/ Plan _____
Have you filed claims for these benefits? _____Yes / _____No

## DECLARATIONS

I/We hereby warrant the truth of the foregoing particulars in every aspect, and agree that if I have made, or if I shall make any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited.

I/We understand that furnishing of this form and other claim forms by the Company does not constitute an admission that there is any insurance in force nor any liability under the Policy.

## AUTHORIZATION

I/We hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person, government institution or private company or entity that has any record or knowledge, to give to Allianz PNB Life Insurance, Inc. or its representative, any information whatsoever with reference to health, hospitalization, consultation, advice, examination, treatment or ailment, birth, death, marriage, employment and education of the Insured. A photocopy of this authorization shall be as effective and valid as the original.

I hereby expressly authorize Allianz PNB Life Insurance, Inc. to obtain, collect, record, organize, store, update, modify, use, share, transfer, disclose and/or destroy ("process"), whether manually or via electronic channels, any and all information, including personal and sensitive information, about me, the life insured, and/or my policy/ies, to 1) facilitate, monitor, and improve the quality of my policy/ies and such services availed of by me, through programs including but not limited to customer satisfaction surveys, offer of related products and services, and statistical, actuarial and risk analyses, and to 2) comply with legal or regulatory obligations of Allianz PNB Life Insurance, Inc. under applicable local or foreign laws, rules and regulations relating to matters including but not limited to anti-money laundering and tax monitoring/review/reporting. I also expressly authorize Allianz PNB Life Insurance, Inc. to share, transfer and/or disclose the said information to any of its intermediaries, branches, subsidiaries, affiliates, service providers, partners and government agencies for the said purposes. I likewise promise to inform Allianz PNB Life Insurance, Inc. of any changes relating to my personal information.

_____ Printed Name & Signature of Insured

_____ Printed Name & Signature of Policyowner

On this _____ day of _____, 20_____ personally appeared before me the above named_____, who being by me duly sworn, deposed that the answers to the above questions are full and true, to the best of his/her knowledge, information and belief, and subscribed the same in my presence.

Affiant exhibited to me his/her Residence Certificate No._____ issued at_____ on _____.

Doc.No._____;
Page No._____;
Book No._____;
Series of _____.

NOTARY PUBLIC

THIS STATEMENT MUST BE MADE BEFORE A NOTARY PUBLIC OR OTHER OFFICER DULY AUTHORIZED TO ADMINISTER OATHS AND HIS OFFICIAL SEAL ATTACHED, OR IF HE HAS NO SEAL, AUTHORITY AND THE GENUINENESS OF HIS SIGNATURE MUST BE ATTESTED BY A MUNICIPAL JUDGE OR BY THE CLERK OF COURT OF RECORD.