PARAMOUNT
LIFE & GENERAL
INSURANCE

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Legaspi Village, Makati City, 1229 Philippines
Tel. No.: (632) 8772 9200
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www.paramount.com.ph

PLEASE APPROVE MEDICAL INFORMATION AUTHORIZATION ON REVERSE SIDE

ATTENDING PHYSICIAN'S STATEMENT

ACCIDENT AND SICKNESS

Patient's name _____ Age _____

1. Nature of the sickness or injury (Describe complications, if any)		Date
2. When did the symptoms first appear or accident happen?		Date
3. When did the patient first consult you for this condition?		Date
4. Has patient ever had the same or similar condition before? (If "yes", state when and describe). Yes [ ] No [ ]		
5. Describe any other disease or infirmity affecting present condition.		
6. Is the patient still under your care for this condition?		
if discharged, give date		
7. Give dates of treatment.	Call	Charge per
	Office	₱
	Home	₱
	Hospital	₱
8. Nature of surgical or obstetrical procedure performed; if any (describe fully). Indicate charge for this procedure and date performed.	Cost of Procedure	Date Procedure was performed
9. If patient hospitalized, give name and address of the hospital.		
Name & Address of Hospital	*Date Admitted*	*Date Discharged*
10. How long was or will the patient be unable to work?	From (mm/yyyy)	through (mm/yyyy)
11. How long was or will patient be partially disabled?	From (mm/yyyy)	through (mm/yyyy)
12. If sickness, was patient confined at home? Yes [ ] No [ ] (if "yes", give dates.)	From (mm/yyyy)	through (mm/yyyy)
13. Is condition due to injury or sickness arising out of patient's employment? If "yes" explain		

REMARKS

Signed _____ Date _____ 20 _____

Signature Over Printed Name of Attending Physician

Telephone / Mobile No. _____

_____ _____ _____

Street Address City / Town Province

CLAIM REPORT ACCIDENT OR SICKNESS

CLAIMANT'S STATEMENT

Claimant's Name (If Dependent):				Policy No:
Insured's Name:				
Address	Street	City/Town	Province	Phone
Policy		Date of Last Payment		To Whom Paid
Occupation		Birth Date		Height Weight
Duties				Certificate No.
Employer's Name		Address		

1. Nature of sickness or injury	Describe	
2. Date you entirely stopped working.	Date	Exact Time
3. Date the accident occurred or sickness began.	Date	Exact Time
4. If sickness, when were symptoms first noticed?	Date	
5. Has this disease caused previous trouble?_____(IF YES, GIVE DATES)	Dates	
6. If injured, how and where did the accident occur?		
7. If vehicular accident, indicate name of car owners?	Names	Addresses
8. What insurance companies are involved?	Names	
9. Date you first consulted a physician for this sickness or injury	Date	
10. Give names of all physicians consulted for this sickness or injury	Name	
11. How long were you continuously confined at home?		
12. How long were you confined to a hospital?		
13. On what date did you, or do you expect to resume light work?		
Usual duties?		
14. What other type of insurance (Life, Accident, Disability Hospital or Medical Expense) do you have? If any, please state_____	Company	Amount of Insurance
15. Are you filing claim under the Workmen's Compensation Act?		

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 a 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."

I hereby certify that the foregoing statements are true and correct, to the best of my knowledge.

_____	_____
Date	Claimant's Signature Over Printed Name

IMPORTANT: Statement of account from the hospital; Hospital itemized receipts; Doctor's fee; Prescriptions; Invoices/official receipts of medicines purchased outside the hospital, etc., must be attached on all claims for medical surgical expenses.

For Death Claim: Death certificate, Birth certificate (insured & beneficiary); Medico legal report; Post mortem report; Police report; Medical certificate; Marriage contract (if married); Certificate of insurance.

MEDICAL INFORMATION AUTHORIZATION

This authorizes PARAMOUNT LIFE & GENERAL INSURANCE CORPORATION (the "PLGIC") or its authorized representative(s) to secure whatever information or records from any Physician, Clinic or Hospital, or any governmental or private body or agency, regarding my illness or injury for which I have been treated or examined, or has been the subject of an investigation. This authorization is being made in connection with my claim on the Insurance Certificate/Policy issued by PLGIC.

This further authorizes PLGIC to process, whether manually or via electronic channels, any personal data secured/collected in relation to this authorization (a) to verify and/or confirm any or all the information provided or representation made, (b) to provide, facilitate, monitor, improve the quality of, or otherwise service my account and such products, services, and facilities and/or channels availed by me or may be offered by PLGIC, (c) for marketing purposes, (d) for client/customer profiling, and (d) to comply with legal, regulatory or other obligations of PLGIC under applicable local or foreign laws, rules and regulations. This also authorizes PLGIC to disclose the personal data to third parties for the foregoing purposes.

This authorization discharges the Physician, Clinic or Hospital, or any governmental or private body or agency, or an authorized member of their staff from any responsibility or obligation in connection with the release of such record or information to PLGIC or its authorized representative. A facsimile or reproduction of this Authorization shall be as valid and binding as the original.

The personal data collected and processed shall be retained by the PLGIC for at least ninety-nine (99) years, or for a longer period if the personal data is related to or required to be preserved for litigation or to comply with legal or regulatory requirement. Any personal data which may be inaccurate or incorrect shall be corrected, amended, deleted and/or disposed by PLGIC, its subsidiaries, affiliates, directors, officers, employees, agents, and authorized third parties. The authorizations hereby given may be revoked or withdrawn through formal written notice to the PLGIC.

Approved by: _____ M.D. Claimant's Signature _____