FOR OFFICE USE ONLY

Claim Reference No.:

Policy Number(s)

Hospitalization Claim Form
(Claimant's Statement)

FOR OFFICE USE ONLY

This serves as an acknowledgement receipt and initial advice of claims requirements if initialized.

Date Received:

Time Received:

Receiving Dept./Office:

IMPORTANT NOTES

We understand that this claim is important to you. In order for us to speed up the process, please (1) complete this form, (2) prepare the relevant documents listed on Section 1, and (3) submit the complete requirements to your Financial Partner or AXA Service Center.

This form is to be filled out by the claimant. Please do not sign on a blank form. No fees, commissions or charges of whatever nature are payable to Financial Partners or Employees of the Company with respect to this claim. Thank you.

FOR WITNESS ONLY

This section is to be accomplished by the AXA Representative who validated the identity of claimant and authenticated the documents received.

Full Name:

Designation/Branch:

Date and Signature:

1. CLAIM REQUIREMENTS

- ❍ Claimant's Statement - duly accomplished and signed by the claimant
- ❍ Original or Certified True Copy of the Statement of Account (SOA) from the hospital
- ❍ Medical certificate - stating the diagnosis and treatment of the attending physician
- ❍ Valid ID of the Claimant - present the actual ID(s) and submit photocopy(ies)
  - At least one government-issued ID with date of birth, signature, and photo.

NOTE: Claims Department reserves the right to request for any additional documents or proof thereof, as it sees fit.

2. INSURED'S INFORMATION

Full Name of Insured ***(last name, first name, middle name)***

Date of Birth ***(mm/dd/yyyy)***

Home Tel. No.

Mobile Tel. No.

Email Address

Residence / Present Address

3. CLAIM DETAILS

Date of Admission (mm/dd/yyyy)

Date of Discharge (mm/dd/yyyy)

Diagnosis

4. CLAIMANT'S INFORMATION (Fill out if different from the Insured)

Full Name of Claimant *(last name, first name, middle name)*

Please mark whichever applies

◯ Owner ◯ Others (Relationship to insured): _____

Date of Birth *(mm/dd/yyyy)*

Place of Birth

Home Tel. No.

Nature of Work

Mobile Tel. No.

Residence/Present Address

Email Address

Preferred mode of communication *(Select one)* ◯ E-mail ◯ Regular Mail

Is the beneficiary a US citizen or a US tax resident? *(If yes, please provide US TIN/SSN)* ◯ Yes ◯ No **US TIN/SSN:**

5. PAYMENT INSTRUCTIONS (Choose 1 of 2 options)

◯ **FUND TRANSFER** (Applicable for both Peso and Dollar policies). Please fill out Direct Credit to Account Section and submit proof of bank account ownership.
Reminder: Fund transfer is only allowed to the bank account of the Policy Owner.

REQUEST FOR DIRECT CREDIT TO BANK ACCOUNT

Account type: ◯ Peso account ◯ Dollar account

Bank Name: ◯ Metrobank ◯ Others:_____

Account Number of Payee:

Branch Name:

Swift Code (for Non-Metrobank)

Account Name of Payee:

◯ **CHECK PAYMENT** (Applicable for both Peso and Dollar policies). Please bring a valid ID when claiming the check.
Reminder: For Peso check: 3-working day clearing period. For Dollar check: 45-working day clearing period.
For representatives, please bring a valid ID, Letter of Authorization (LOA) for amounts less than Php 50,000.00, or a notarized Special Power of Attorney (SPA) for amounts greater than or equal to Php 50,000.

◯ I will pick up the Check at AXA Service Center:

Declarations and Agreements:

1. I declare that the proceeds of this application/policy once deposited to the account aforementioned shall be equivalent to payment to me directly of the same and I shall render AXA Philippines, its successors-in- interests and assigns, including its directors, officers, employees and agents, free and harmless from any further claim, demand or action whatsoever, which in law or equity I ever had, now have, or which I, my successors and assigns hereafter may have under this said application/policy.
2. I understand that should the proceeds be credited to a non-Metrobank account, corresponding fees shall be charged to my account.
3. I, the undersigned, also take full responsibility in the accuracy of the account name and number indicated above. Should there be any error(s) in the information, I understand that this will result to delays in the crediting of the policy proceeds and I shall bear the consequences.
4. I understand that the information I provided will be validated and authenticated by AXA Philippines.
5. Before signing this declarations and agreements, I have read and understood all declarations and agreements which are hereby given and made willingly and voluntarily and with full knowledge of my rights under the law.

Signature over printed name of policy owner *(if minor, designated guardian)*

Date of signing *(mm/dd/yyyy)*

6. AUTHORIZATION

To whom it may concern:

I hereby authorize AXA Philippines and/or its duly authorized representative to secure whatever information and/or records from any employer, physician, hospital/clinic, other medically related facility, and organization/institution or person, who has records and/or knowledge with regards to sickness and/or injury of _____. This is in connection with the claim on the insurance policy(ies) of the insured.

(Full Name of Insured)

Signature over printed name of claimant

Date of signing *(mm/dd/yyyy)*

7. DECLARATIONS

1. Before signing this Claim Form, I declare that I have carefully read, understood, and agree with all the instructions and questions that are written. I further understand, declare and agree that all statements and answers made in this Claim Form, and all documents attached, are to the best of my knowledge and belief, complete and true, correctly recorded, and shall form part of and be the basis of claim assessment and approval. All the information I provided on this application form are to the best of my knowledge true and correct.

2. Any of my personal information collected or held by AXA Philippines (whether contained in the application/s or otherwise), may be used, stored, disclosed, transferred (whether within or outside the Philippines) to such persons as AXA Philippines may consider necessary, including without limitation but not limited to any of its affiliated or related companies, or any individuals/organizations/corporations/entities associated with AXA Philippines:
   a. to process and deal with my claims request;
   b. to provide all services related to said request; and
   c. to communicate with me for any purpose and/or to comply with the laws of any applicable jurisdiction.

3. I understand that I have the right to access our personal information at any time; correct or rectify any information collected or held by AXA Philippines which are inaccurate, false, or incomplete; object in case of any unauthorized collection; erase or block information which is complete, outdated and false; and such other rights as may be available under the Data Privacy Act. I understand that such request may be made in writing and submitted to AXA Philippines.

4. I understand that notices related to my claim may be sent to me through mail, email or SMS in the address/number I provided above.

Signature over printed name of claimant

Date of signing *(mm/dd/yyyy)*