redefining / standards

Policy Number(s)

Disability/Critical Illness/Hospitalization Claim Form (Claimant's Statement)

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 page 3 and (3) Submit the form to your agent or AXA Office.

This form is to be filled by the claimant. Please do not sign on blank form. No fees, commission or charges of whatever nature are payable to Agents or Employees of the Company in respect of this claim. Thank you"

FOR OFFICE USE ONLY

Date Received:

Time Received:

Receiving Dept./Office:

FOR DISTRIBUTOR'S USE ONLY

FE/Advisor's code:

FE/Advisor's name:

FE/Advisor's mobile number:

1. General Information:

Who is suffering from disability[8] as will be described in this Claim Form?

◯ Policy Owner who is also the Insured ◯ Insured who is different from Policy Owner ◯ Policy Owner who is different from Insured

Full Name of Insured/Owner who is suffering from disability:

Date of Birth: (yyyy/mm/dd)

Current Occupation: (Please state exact nature)

2. Claim Types:

Type of Disability Benefit/s to Claim:

◯ ADD&D[2] ◯ TPD[4]/TPDIB[5] ◯ WP[6]/WPDD[7]

Type of Hospitalization Benefit/s to Claim:

◯ MEB[2] ◯ AME[3]

Type of Critical Illness Benefit/s to Claim:

◯ ELI

3. About Current Claim:

What particular disability is the Insured/Owner suffering from?

Date the illness was first diagnosed:

Please shade below the Activities of Daily Living (ADL) that the Insured/Owner is currently UNABLE to perform without assistance:

◯ Ability to feed oneself
◯ Ability to move from room to room on level surface
◯ Ability to attend to own toilet needs
◯ Ability to wash and bath oneself
◯ Ability to get in and out of bed
◯ Ability to dress

If due to illness, please provide details below:

Chief complaints for consultation:

Date symptoms discovered/felt:

Date of first consultation:

Health History:

Date (yyyy/mm/dd)	Name and Address of the Hospital/Clinic:	Diagnosis and Treatment	Doctor's Name	Contact Number

Definition of terms:

1. *Rightful claimant must be in the following heirarchy order:*
   a. *Insured*
   b. *Policy Owner if Insured is incapable to file the claim*
   c. *Reperesentative w/ SPA if Insured is the sames as Policy Owner, and he is incapable to file the claim*
2. *ADD&D*
   - *refers to Accidental Death, Dismemberment & Disablement of the Insured*
3. *AP/ADD*
   - *refers to Accidental Death & Dismemberment of the Insured*
4. *TPD*
   - *refers to Total & Permanent Disability of the Insured*
5. *TPDIB*
   - *rerers to Total & Permanent Disability Income Benefit for the Insured*
6. *WP*
   - *refers to Waiver of Premium due to the Disability of the Insured*
7. *WPDD*
   - *refers to Waiver of Premium due to Death & Disability of the Policy Owner*
8. *Disability*
   - *refers to inability or decreased ability of performing the usual duties of one's occupation or activities of daily living due to sickness or accident*

4. If this claim is due to accident, please complete this section:

If due to accident please provide details below:

Details of Injury(ies) Sustained:

Date & time of accident:

Place of accident:

5. If this claim requires hospitalization benefit, please complete this section:

Date of admission:		**Date of discharge:**	
Doctor's diagnosis:			

6. Payment Instructions (Choose 1 of 3 options)

◯ **FUND TRANSFER** (Applicable for both Peso and Dollar policies). Please fill out Direct Credit to Account Form (Annex A)

◯ **CASH PAYMENT** (Applicable only for Peso-denominated policies wherein claimant applies for claim personally at the Head office and the claim is approved during the same day of application. Maximum amount that can be released for Cash Payment is Php 100,000. Cash Payment is not offered to claim applications made through a Representative.)

◯ **CHECK PAYMENT** (Applicable for both Peso and Dollar policies). Please choose below your preferred mode of check delivery.

◯ I will pick up the Check at

◯ AXA Head office ◯ AXA Branch:

◯ Thru my Personal Representative

Name:

◯ Thru my Billing Address:(House No./Street) (Brgy) (City) (Province) (Zipcode)

7. Declarations and Authorizations:

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 herewith. I further understand, declare and agree that all statements and answers made in this Claim Form, whether or not written by my own hand, and all documents attached herewith, 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.
2. Furthermore, I hereby authorize AXA Philippines and/or its duly authorized representative to secure whatever information and/or records from any physician, hospital/clinic, other medically related facility, and any organization/institution or person who has any records and/or knowledge concerning my DISABILITY or condition with respect to this Claim.
3. All the information I/we provided on this application from are to the best of my knowledge true and correct.
4. Any of my/our personal information collected or held by AXA Philippines (whether contained in the application/s or otherwise), may be used in connection with matching for whatever purpose with such other personal information and/or may be used, stored, disclosed, transferred (whether within or outside the Philippines) to such persons as AXA Philippines may consider necessary, including but not limited to any of its affiliated companies, or any individuals/ organizations associated with AXA Philippines:
   a. to process and deal with the application
   b. to provide all services related to the application and promote the services by AXA Philippines and its affiliated companies
   c. to communicate with me for any purpose and/or comply with the laws of any applicable jurisdiction.
5. I/We have the right to request access to and correct any of my personal information held by AXA Philippines. I/We understand that such request may be made in writing and submitted to the Policy Services Unit of AXA Philippines
6. I/We understand that AXA shall use my/our personal information to evaluate and assess my/our application and need for life insurance and investments, as well as to service any of my/our policies and needs including the evaluation of any future claims. I/We also authorize AXA to disclose to affiliated entity(ies) or to persons or entities providing services on AXA's behalf consistent with the purpose for which the information was obtained.
7. I understand that notices related to my policy may be sent to me through mail, email or SMS in the address/number I provided above.

If Claimant is other than the Insured, or if there are changes in the current information, kindly fill out the spaces below as these will be use to update policy record.

Full Name of Claimant:

Relationship to Insured[9]: | **Home Tel. No.:** | **Mobile Tel. No.:** | **Email Address:**

Complete Residence Address: (Please include Zip Code)

Signature of Claimant:

Place of Signing:

Date of Signing: (yyyy/mm/dd)

8. Your Guide To Your Claim Requirements

Please shade the requirements submitted. Also, please note that AXA Philippines reserves the right to seek additional requirements as deemed necessary.

Basic / Routine

- ❍ **Claimant Statement Form** - duly accomplished and signed by the claimant(s)
- ❍ **Attending Physician Statement Form (depends on the type of claim i.e. medical, critical illness, disability)** - duly accomplished and signed by the Attending Physician
- ❍ **Complete Medical records -** to include copy of actual admitting history, discharge summary and all laboratory or work up results. (in-patient or out-patient consultation from clinics or hospitals. Should include Operation technique/Operation report if amputation or dis articulation was performed and claiming for Accident or Disability or Waiver of Premium.
  May be optional if insurance policy is more than 2 years active and claiming only for Hospital Indemnity.
- ❍ **Original or Certified True Copy of the Statement of Account (SOA) from the hospital** - In the absence of the SOA, you may submit a Hospital Certification signed by an authorized personnel from the Billing or Records Section of the Hospital stating the inclusive confinement dates. Original or Certified True Copy of the Statement of Account (SOA) from the hospital when claiming **for Hospital Claim (Medical Expense Benefit)**
- ❍ **Medical certificate** - stating the diagnosis and treatment of the physician for hospital confinement within 7 days
- ❍ **Valid ID** of the Claimant(s) - present the actual ID(s) and submit photocopy(ies)
  - Present at least one Primary ID as shown below:
    ❍ SSS ID / GSIS ID ❍ Driver's License ❍ Passport ❍ Voter's ID ❍ Any Government ID (with photo & signature)
  - In the absence of Primary ID's, present at least two ID's as shown below
    ❍ Employment ID ❍ School ID ❍ ATM Card ❍ Credit Card ❍ HMO Card ❍ Birth Certificate

Additional requirements for Disability Claim (accident, disability, waiver of premium)

- ❍ **Complete Medical Records** Should include operation technique/operation report if amputation or disarticulation was performed and claiming for accident or disability or waiver of premium.

9. Track your Claim Status

Once your claim is registered, you will be updated through SMS. If you have any query on your claim, please reach us on

+632 5815-AXA (292)
+632 3231-AXA (292)

claims@axa.com.ph

AXA is committed to making your insurance claim process as easy and stress-free as possible. Thank you for insuring with us. We are always glad to be of service.

(Annex A)

REQUEST FOR DIRECT CREDIT TO BANK ACCOUNT

Policy No.:

Account type:

◯ Peso account ◯ Dollar account

Account Number of Payee:

Bank Name:

◯ Metrobank ◯ Others: _____

Account Name of Payee:

Branch Name:

Swift Code (for Non-Metrobank)

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 declare that in the event the account aforementioned is owned by person other than me, the account owner is my relative and that I had sought his/her consent to use his/her account to facilitate the payment to me of the proceeds of this application.
3. I understand that should the proceeds be credited to a non-Metrobank account, corresponding fees shall be charged to my account.
4. I/We, 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/We understand that this will result to delays in the crediting of the policy proceeds and I/We shall bear the consequences.
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."

Relationship of claimant to Account Owner

_____
Signature Over Printed Name of the Policy Owner

_____
Signature Over Printed Name of the Account Owner
(If claimant is different from Account Owner)

Note: Third Party Account Owner is only limited to:
1. Spouse 2. Children 3. Parents 4. Siblings

Account Name and No. verified true and correct by:

_____
Signature Over Printed Name
of BOO/ Branch Head