Policy Number

–

Application Number H_____

Global Health Access Reimbursement Form

This form is to be filled out by the claimant, if the claimant is under 18 years old, parent/guardian should accomplish it in behalf of the minor.

Please Ensure that your signature tallies with the signature that is provided to AXA.

1. Details of the Claimant (all fields are mandatory)

Full name of Insured Claimant (LAST NAME, FIRST NAME, MIDDLE NAME):

Full Name of Policy Owner, if not the same as insured claimant (LAST NAME, FIRST NAME, MIDDLE NAME):

Contact details of claimant or of guardian if claimant is a minor:

Mobile Number:

Email Address:

2. Claim Type (you may tick off as many as the number of claims you are submitting)

- ◯ Health Screening
- ◯ Inpatient Benefit
- ◯ Outpatient Consultation
- ◯ Pre and Post Hospitalization Benefit
- ◯ Dental/Optical
- ◯ Cash Benefit *(For cash benefit, submit SOA)*
- ◯ Maternity Benefit
- ◯ Emergency Benefit *(there is a separate box C and D)*

3. Claim Details

A. If Health Screening

ECU Package (Please attach official receipt)

Hospital/Clinic + Location

Date and Time of Health Screening

B. If Confinement or Inpatient

Initial Diagnosis

Final Diagnosis

Date and Time of confinement

Surgical Procedure done

Date patient first became aware of any signs or symptoms for this condition

Date(s) of Confinement

Treating Doctor/s:

C. If Outpatient Consultation or Treatment (Includes Emergency Room Availment)

Initial Diagnosis

Final Diagnosis

Includes Emergency Room Availment/Pre and Post hospitalization Availment

Type of treatment or medicine received
(Please attach Doctor's orders/prescriptions and Official receipts)

Date patient first became aware of any signs or symptoms for this condition

Date(s) of Treatment/Confinement

Treating Doctor

D. If Emergency Room treatment due to Accident-related injury

Nature of Incident/Cause (NOI):

Date of Incident:

Place of Incident:

Diagnosis to include injury details and Official receipts

4. Breakdown of Claim (Please use back sheet if more space is needed)

Type of Claim	Receipt Date	Receipt Details	Amount to be Claimed
SUM:			

5. Supporting Document Submitted with this form

Please tick against the documents you have submitted together with this reimbursement form. We will notify you or your Financial Executive/Financial Advisor/Broker if we need to obtain additional information from you or from other parties to assess your claims.

- ◯ Completed original Reimbursement Form
- ◯ Original final itemized medical bills, proof of payment, receipts
- ◯ Admitting and discharge history (If applicable), doctor's prescriptions

If you have any questions regarding this form or any other aspects of the coverage, please contact our Global Health Access Hotline at (02) 858-15207 or 1-800-1888-8292 (AXA). Claims must be submitted along with all supporting documents within 30 days from date of treatment. Send this claim form together with all supporting documents to any AXA Service Center most accessible to you.

6. Declaration

I declare that:

1. The information that is disclosed on this reimbursement claims form is true, complete, and accurate, and that no material information has been withheld or is any relevant circumstances omitted.

2. I HEREBY AUTHORIZE any employer, registered medical practitioner, hospital, clinic, insurance company, health maintenance organization, bank, government institution, or person, that has any records or knowledge of the insured claimant _____ with _____ (SSS ID/GSIS ID/Driver's License/Passport Number/Voter's ID/Any Government ID (with photo and signature)), to disclose and make available to AXA Philippines such details and records as may be requested by the company.

3. By providing this information, I understand and give my consent for AXA and its respective representatives or agents to:

   i. Collect, use, store, transfer, and/or disclose the information, to or with all such persons (including AXA or any third party service provider, and whether within or outside of the Philippines), for the purpose of enabling AXA to provide me with services required of an insurance provider, including the evaluating, processing, administering, and/or managing of my or our relationship and policy(ies) with AXA and for the purposes set out in AXA's Privacy Policy which can be found at www.axa.com.ph/legal-disclaimer
   ii. Collect, use, store, transfer, and/or disclose personal data about me, the Insured Person and those whose personal data I have provided from sources other than myself for these Purposes

4. I am happy to receive customer service communication by e-mail and/or SMS.

IMPORTANT: PLEASE DO NOT SIGN ON A BLANK FORM

Signature over Printed Name of Policy

Signature over Printed Name of Insured

Date (mm/dd/yyyy)

7. Claims Settlement Bank Account Details

Payment will be made in Philippine Peso (PHP)

Bank Name

◯ Metrobank ◯ Others: _____

Branch Name/Bank Address

Account Number of Insured Claimant or Guardian (If insured is a minor)

Account Name of Insured Claimant or Guardian (If insured is a minor)

Declarations and Agreements:

1. I declare that the proceeds of this claim 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/We, the undersigned, also take full responsibility in the accuracy of the account name and number indicated above. Should there be any errors 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.

4. 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 the Insured Claimant/Policy Owner