MAAGAP INSURANCE, INC.

# ACCIDENT OR SICKNESS CLAIM REPORT

MAAGAP-AF-UW-051 REV-02

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|---|---|---|
| Policy No. | Policy Date | Claim No. |
| Name of Policyholder | | Tel. No. |
| Name of Insured/Claimant | | Age |
| Business Address | | Tel. No |
| Residence Address of Insured | | Tel. No |

Occupation (describe fully)

Place of Accident

Date & Time Injured

Month Day Year Time (am/pm)

Describe how Accident occurred

Name of Police Station and Investigator

Extent and nature of injury or sickness

Names & Addresses of Witness (if any)

Place and Duration of Confinement ] House, From: To:
] Hospital From: To:

Give Names, Addresses and Tel. No. of all physicians consulted for the injury

Name Address Tel. No.

Name Address Tel. No.

If hospitalized, State Name, Address and Tel. No. of Hospital

Do you have other Accident or Sickness Insurance? [ ] No [ ] Yes

(State Name & Address of Insurance Company)

**FRAUD WARNING STATEMENT:**

**"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."**

**DECLARATION AND AUTHORIZATION**

I hereby declare all the statements to all questions above, whether or not written by my own hand are all to the best of my knowledge and belief complete and true. I agree that any concealment or misstatement as regards to the amount or otherwise, in connection with this claim may result in prosecution and the policy shall become void. I hereby authorize any physician, hospital, pharmacy, insurance company, police station or any other organization who has records or knowledge of myself or the Insured, to release MAAGAP Insurance Inc. all information regarding my medical history, prognosis, treatment (including drug and alcohol abuse information) or benefit payable under other insurance coverage to a machine copy of this Declaration and Authorization shall be effective and valid as the original.

DATE : Signature : _____

INSURED/CLAIMANT/PARENT/LEGAL GUARDIAN

# EMPLOYMENT CERTIFICATION

This is to certify that Mr./Ms. _____ with ID No. ____ is a regular/contractual/probationary employee of _____ employed as _____ from _____ to _____.

Issued this ____ day of _____ year ____.

_____
Authorize Signatory/Designation
Signature Over Printed Name

# ATTENDING PHYSICIAN' S REPORT

**PATIENT'S NAME** **AGE** **SEX**

1. Nature of Injury _____
   a. Chief Complaint _____
   b. Final Diagnosis _____
   c. Complication, if any _____
   d. If fracture or dislocation, state whether complete or incomplete _____

2. When was the patient's first consultation for this condition? _____
3. Nature of surgical or obstetrical procedure, if any _____

4. Was patient hospitalized? [ ] Yes [ ] No
   Name of Hospital _
   Address _
   Date Admitted _
   Date Discharged _

Address : _____

_____
Signature over Printed Name

Date : _____
Narcotics License No. _____
TIN _____

Physician _____
License NO. _____
P.T.R. _____
Date Issued _____
Issued at _____
On _____

**INSTRUCTIONS TO CLAIMANT:**

1. Accomplish the Accident Insurance Claim Report
2. Submit the following basic documents:
   a. Police Investigation Report
   b. Medical Certificates and original copy of Hospital Statement of Accounts;
   c. Original Official Receipts of hospital bills/professional fees;
   d. Original Official Receipts of medicines purchased outside the hospital and their prescriptions;
   e. For Accidental Death Claim, submit also the Birth Certificate and Death Certificates, Autopsy Report, Marriage Contract any such documents that will establish the relation of the Insured to the Claimant/Beneficiary
   f. Proof of Employment

**DATA PRIVACY NOTICE**

By providing your personal data and other information through our Services and Products, you acknowledge that your personal information will be processed pursuant to the terms of our Privacy Policy.

Our Privacy Policy can be viewed online at www.maagap.com or we can provide you with a copy upon request.
If you have any questions or comments about our Privacy Policy and practices, please contact our Data Protection Officer (DPO) via email at dpo@maagap.com

**CONSENT**

In compliance with the Data Privacy Act of 2012 and its Implementing Rules and Regulations, I hereby give my consent to the collection and processing of my personal information in connection with this application and for other related processes necessary thereto.