ACCIDENT OR SICKNESS CLAIM REPORT

MAAGAP-AF-UW-051 REV-02

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: [ ] Hospital From:	To: 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.