

# PERSONAL ACCIDENT CLAIM FORM



INSURING GROWTH

1. Notify the Insurance in case of claim within 30 days from the date of loss.
2. Forward the accomplished Accident Claim Report form together with all the necessary documents within 90 days from the date of loss.

*The form should be completed truthfully and accurately.*

*The acceptance of this is NOT an admission of liability on the part of Prudential Guarantee & Assurance Inc ("the Company").*

*Any documentary proof or report required by the Company shall be furnished by the Policyholder or Claimant.*

NAME of INSURED: \_\_\_\_\_ POLICY NO.: \_\_\_\_\_  
NAME of CLAIMANT: \_\_\_\_\_ BIRTHDAY: \_\_\_\_\_  
DATE OF ACCIDENT: \_\_\_\_\_  
DESCRIPTION OF ACCIDENT: \_\_\_\_\_

(If claim arising due to vehicular accident, please provide police report.)

ATTENDING PHYSICIAN'S STATEMENT: (to be filled out and signed by attending physician)

DIAGNOSIS OF INJURY: \_\_\_\_\_

DATE OF FIRST CONSULTATION : \_\_\_\_\_

Is condition due to injury? YES NO

RECOMMENDED LABORATORY AND OTHER PHYSICAL EXAMINATION PROCEDURE/S:

Did the injury require hospitalization? YES NO

If YES, please state period of confinement: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

(Please provide complete medical records from the hospital)

Did the condition require surgery? \_\_\_\_\_

Did the condition require physical therapy and rehabilitation after surgery/treatment? \_\_\_\_\_

How long? \_\_\_\_\_

PROGNOSIS: \_\_\_\_\_

NAME OF HOSPITAL : \_\_\_\_\_

ADDRESS : \_\_\_\_\_

*I hereby certify that I have personally examined and treated the patient's injuries/sickness and present my findings on his/her condition as stated above.*

\_\_\_\_\_  
NAME OF PHYSICIAN

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
LICENSE NO. OR PTR NO.

\_\_\_\_\_  
DATE

*I HEREBY CERTIFY that the foregoing statements are true and correct to the best of my knowledge.*

\_\_\_\_\_  
CLAIMANT'S SIGNATURE

\_\_\_\_\_  
DATE

MEDICAL INFORMATION AUTHORIZATION: I HEREBY AUTHORIZE any hospital physician of other person who has attended to me or examined me, to disclose when requested to do so by PRUDENTIAL GUARANTEE AND ASSURANCE, INC. or its representative any and all information, prescriptions or treatment, with respect to any illness or injury, medical history and copies of all medical or hospital records. A photostatic copy of this authorization shall be considered as affective and valid as the ORIGINAL.

APPROVED: \_\_\_\_\_ (M.D.)  
Signature over Printed Name

\_\_\_\_\_  
Claimant's Signature

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LIST OF SUPPORTING DOCUMENTS TO BE ATTACHED ON THE CLAIM FORM:

MEDICAL REIMBURSEMENT:

1. Original Medical Bills and Official Receipts
2. Copy of Doctor's Prescription
3. Copy of Hospital Statement of Account
4. Police Report or Accident Report (especially for a vehicular accident claim)
5. Copy of the results of laboratory and other physical examination/s results

DEATH CLAIM:

1. Duly registered death certificate or certified true copy
2. Duly registered birth certificate of the insured
3. Autopsy Report/Medico Legal statement
4. Official police report and other related reports i.e. interoffice accident report, newspaper clippings, etc.
5. Affidavit of witness/es (if applicable)
6. Available photos taken at incident scene
7. Proof of relationship of the beneficiary (such as marriage contract, birth certificate, baptismal, etc.)
8. Copy of driver's license (if the insured is the one driving the vehicle) for a vehicular accident claim.

***The Company reserves the right to request for additional documents as the need arises. Also, this communication should not be construed as an admission of the Company's liability nor waiver of its rights and privileges under the said policy.***