Allianz PNB LIFE INSURANCE

International Health Claim Form

INTERNATIONAL HEALTH CLAIM FORM

Policy No. _____

PART 1 - STATEMENT OF CLAIMANT FOR INTERNATIONAL HEALTH (To be accomplished by the Policyowner)

INFORMATION ON THE INSURED

Full Name (Last Name, First Name, Middle Name)

Mobile No. (Required)

Email Address (Required)

Country of Residence

Occupation

DETAILS OF THE ACCIDENT

Nature of the accident ☐ Work Accident ☐ Road Accident ☐ Others _____

Date of Accident

Place of Accident

Describe the cause and other details relating to the accident

Describe the extent of the injury/ies in detail

Diagnosis of the Attending Physician

Prescribed medicines or treatment

DETAILS OF THE ILLNESS

Describe the nature and symptoms of your illness/disease

Date the symptoms first occurred

Date of consultation

Diagnosis of the Attending Physician

Prescribed medicines or treatment

Have you had this condition or a similar one previously? Please provide details.

Allianz PNB LIFE INSURANCE

International Health Claim Form

REGULAR PHYSICIANS OR FAMILY DOCTORS *(Use separate sheet if necessary)*

Physician's Name	Clinic/Hospital Affiliations	Contact Nos.

OTHER INSURANCE CLAIMS

Do you have other medical plans with any other insurance company or Health Maintenance Organization (HMO)? ☐ Yes ☐ No

If "Yes", please provide the company name and policy no.

Have you filed claims for these benefits with these companies? ☐ Yes ☐ No

BENEFIT PAYMENT OPTIONS

Preferred payout option ☐ Check ☐ Fund Transfer (fill-up Bank Account Details)

BANK ACCOUNT DETAILS *(must be under the name of the policyowner)*

Bank Name

Bank Address

Account Name

Co-depositor's Name (if any)

Account No.

Type of Joint Account ☐ and ☐ and/or

Currency ☐ Peso ☐ US Dollar

DECLARATIONS AND AGREEMENTS

1. I/We hereby warrant the truth of the foregoing particulars in every aspect, and agree that if I have made, or if I shall make any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited*.
2. I/We understand that furnishing of this form and other claim forms by the Company does not constitute an admission that there is any insurance in force nor any liability under the Policy.
3. I/We declare that the proceeds of this policy, whether paid in check or deposited to the declared account, shall render Allianz PNB Life Insurance, Inc., 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.
4. I/We understand that any corresponding bank charges shall be charged to my account.
5. I/We understand that if I choose to convert my reimbursement from Dollar to Peso, the proceeds will be paid out based on an exchange rate determined by the Bankers Association of the Philippines, with an additional spread.
6. I/We take full responsibility in the accuracy of the account name and number indicated above. Should there be any error(s) in the information, I understand that this will result to delays in the crediting of the policy proceeds and I hold Allianz PNB Life Insurance, Inc. free from any liability resulting from the erroneous information.
7. I/We 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.

** 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 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 present or use the same, or to allow it to be presented in support of any claim.*

Allianz PNB LIFE INSURANCE

International Health Claim Form

AUTHORIZATION

I/We hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person, government institution or private company or entity that has any record or knowledge, to give to Allianz PNB Life Insurance, Inc. or its representative, any information whatsoever with reference to health, hospitalization, consultation, advice, examination, treatment or ailment, birth, death, marriage, employment and education of the Insured. A photocopy of this authorization shall be as effective and valid as the original.

Printed Name & Signature of Insured	Printed Name & Signature of Policyowner
Date Signed	**Date Signed**

IMPORTANT REMINDER

For faster facilitation of your request, please ensure that all relevant fields in this form are accomplished. Also make sure to attach a scanned copy of the necessary supporting documents upon submission:

1. Part 2 – Attending Physician's Statement for International Health (only if the claim is more than PHP 5,000)
2. Complete medical/hospital records pertaining to the claim
3. Police or accident reports if claim is due to an accident
4. Prescriptions for medicines
5. Official Receipts

You may submit the completed form and other documents through your financial advisor, or email them to **healthclaims@allianzpnblife.ph**.

Allianz PNB LIFE INSURANCE

International Health Claim Form

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PART 2 - ATTENDING PHYSICIAN'S STATEMENT FOR LIVING BENEFITS

(To be accomplished by the Attending Physician only if claim is more than PHP 5,000)

IMPORTANT NOTICE

This statement must be made by the attending physician of the insured. If more than one physician was employed, the statement of each must be furnished upon on separate forms, which will be sent if required. Indefinite terms as heart failure, exhaustion and the like are to be avoided unless full details are added. Where the spaces set apart for the answers are too small, such details as seem desirable may be given on a separate sheet.

** 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 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 present or use the same, or to allow it to be presented in support of any claim.*

GENERAL INFORMATION

Patient's Name

Name of Hospital

Address of Hospital

Contact Nos. of Hospital

Ward/Room No.

Date and Time of Admission

Date and Time of Discharge

Are you related to the patient by blood or consanguinity? ☐ Yes ☐ No If yes, how? _____

What is your field of specialization?

Are you the regular physician of the patient? ☐ Yes ☐ No If yes, since when? _____

Did any other physician attend to the patient? ☐ Yes ☐ No If yes, please give details below:

Physician's Name	Clinic/Hospital Affiliations	Contact Nos.

DETAILS OF THE ILLNESS

Reason for consultation

Describe the nature and symptoms of the patient's illness/disease

Date the symptoms first occurred

What was the diagnosis?

ICD Code

Is the disease /illness congenital or hereditary?

Allianz PNB
LIFE INSURANCE

International Health Claim Form

DETAILS OF ACCIDENT

What treatments and/or procedures were done to confirm the diagnosis?

Further treatments, consultations and/or procedures required following the diagnosis

Was the patient referred to you by another Medical Practitioner? ☐ Yes ☐ No If yes, please provide the name and contact details.

From what other illness or disease does the insured suffer? Please provide details.

Details of previous consultations

Date of Consultation	Illness / Diagnosis	Procedure / Operation Done	Prescribed Medication

DETAILS OF ACCIDENT

What is the cause of the injury

Date and time of the accident

Did loss/es or disability occur from bodily injury caused solely by the accident? ☐ Yes ☐ No If no, give details of contributory cause/s.

Was the patient under the influence of alcohol/medication at the time of accident? ☐ Yes ☐ No If yes, please give details.

Having been duly sworn, I hereby depose and say that all the statements in the foregoing answers are true and full, to the best of knowledge and belief, and that there are no material facts in the case which are not disclosed.

Dated at _____, this_____ day of _____, 20_____.

Name of Medical Practitioner

Signature of Medical Practitioner

License No.

Date signed