Allianz PNB LIFE INSURANCE

Wellness Reimbursement Form

Policy No. _____

INTERNATIONAL HEALTH WELLNESS REIMBURSEMENT FORM (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

BENEFIT CLAIMED

☐ Health Screening ☐ Vaccination ☐ Hearing and Visual Aid ☐ Physical Activity Program
☐ Nutrition Counseling ☐ Dental ☐ Others _____

DETAILS OF THE CLAIM

OR Date	OR No.	Provider	Details	Amount

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 | Branch

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.*

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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**