PERSONAL ACCIDENT CLAIM FORM

Prudential Guarantee
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

Prudential Guarantee and Assurance, Inc.
COYIUTO HOUSE, 119 Palanca St., Legaspi Village, Makati City
Tel. no. +632 8810 4916

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

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.
