Insurance Claim Form

For Safety Protection Group Policy

CHUBB[®]

Notice to the Insured/Claimant:

Please answer all questions completely and accurately. Indicate "N.A." where a question is not applicable.

To enable us to process your claims promptly, please indicate with a " mark on which benefit you are claiming and submit all required documents for that benefit:

Accidental Death, Burial Assistance or Cash Assistance Benefit

- 1. Birth Certificate of the Insured
- 2. Death Certificate of the Insured
- 3. Original Copy of the Police Report or Barangay Report or Affidavit of Witnesses
- 4. Autopsy Report or Medico-legal Statement
- 5. Photos taken at incident or news clippings, if any
- Proof of Relationship of the Beneficiary (such as Marriage Certificate, Birth Certificate, Baptismal Certificate or Passport)

Fire Insurance Coverage

- 1. Original Copy of the Police Report or Barangay Report or Fire Department Report
- 2. Photos taken at incident or news clippings, if any

___ ATM Theft

- 1. Original Copy of the Police Report or Barangay Report or Fire Department Report
- 2. ATM Transaction Slip or Bank Certification/Document record or G-Cash Certification as proof of the ATM transaction

You will be notified in case additional documents are required. The Company makes no admission of liability or waiver of rights by furnishing this form.

Fraud Warning

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.

Group	Policy	vholder:	G-Xchan	ge. Inc.

Group Policy Number:	
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To Be Completed By the Insured or Claimant (Beneficiary):

Part A: General Information					
Full Name of the Insured:			Name of Claimant (if other than Insured):		
Date of Birth of Insure	ed: DD/MM/YYYY		Date of Birth of Claimant DD / MM / YYYY (if other than Insured):		
Name of the Employer:			Relationship of Claimant to the Insured: Spouse Child Others		
Address of the Employer:		1			
WHEN did the Incide	ent (Death, Fire, ATM Theft) happen?		Describe fully HOW and WHERE the incident occurred:		
Date:	Time:	AM/PM			
If injured in an Accide Name and Address an	ent, please indicate the Physician/Surgeon d the Hospital where you were admitted:	on's :			
Name of Doctor:					
Address of Doctor:					
Name of Hospital:					
Address of Hospital.					
Address of Hospital:					
Date of Confinement:					
From:	То:				
	10.				

Part B: Attending Physician's Statement (to be accomplished by the Physician/Surgeon – For Death Benefit Only)					
1. Patient's Name:		2. Patient's Date of Birth:			
3. Diagnosis and Concurrent Conditions:		4. Confined:	From:		
5. Complete Admitting	g History:				
6. Past Medical Histor	y:				
7. Pertinent Physical E	xamination Findings:				
8. Significant Diagnos	tic Procedure Findings:				
9. Report Services:					
Date of Services	Place of Services	Description of Surgi	cal Procedure or Medical Services Rendered		
10. Is the condition du	e to injury or sickness arising out of				
Patient's Employm	ent? Yes No; If YES , Approximate Da	nte:			
Pregnancy?	Yes No; If YES , Pregnancy Commenced Da	te:			
11. Date symptoms first appeared or when accident happened:		12. Date patient first consulted you for this condition:			
Date condition was	diagnosed:				
13. Patient ever had sa	me or similar condition?				
Yes	No; If YES , When And Describe				
14. Was patient house confined? From		То			
Physician's Name:		Signature:			
Date:		License No.:			
Address:					
Tel No.:		Mobile No.:			
Medical Information Authorization To: Medical Record Section Hospital					
I hereby authorize any hospital, physician, or other person who attended or examined Insured, to disclose when requested to do so by Insurance Company of North America (a Chubb Company), or its representative, any and all information, with respect to above condition, including medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the ORIGINAL.					
Signature over Printed Name of Claimant/Beneficiary M.D.Patient's/Claimant's Signature Date					

 $For Death \ Benefit: Failure \ to \ complete \ Part \ B \ of \ this \ form \ may \ delay \ processing/payment \ of \ your \ Death \ Claim.$

Contact Us

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