Paramount Life & General Insurance Corporation

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Madaling Kausap.

HOSPITALIZATION CLAIM FORM

☐ PrimeCARE Cash Plan ☐ Premium HealthCare Plus Plan ☐ HealthCare Cash Plan ☐ Hospital Income Benefit Plan
☐ The Money Shield Plan ☐ Money Shield Plus Plan ☐ Money Plus Plan ☐ Others _______________

TO HELP US PROCESS YOUR HOSPITALIZATION CLAIM PROMPTLY, PLEASE SUBMIT THE FOLLOWING REQUIREMENTS:

1. This Claim Form properly filled out and signed by you on **Part A** and by your attending doctor on **Part B.**
2. Hospital Admitting History and Discharge Summary.
3. Hospital Statement of Account or Certification from the hospital stating time and date/s of confinement.
4. Laboratory and Diagnostic Results.
5. Record/details of operation (if surgical operation was performed).

PART A (To be accomplished by the insured – PLEASE ANSWER ALL QUESTIONS.)

Policyowner's/Patient's Name: ____Policy Number: _________________
Address: ____E-mail Address:___________________________
Name and Address of Employer: ___________________________________Tel. No. /Mobile No.: ______________________
SSS/GSIS Number: __________________________________Other Health Insurance: ________________________________

1. Are you taking maintenance medications? _____________What medicines? ___________________________________
   ____Since when? _______________________________________
2. Name of doctor who prescribed your maintenance medication: ____
3. Address of clinic or hospital of doctor who prescribed maintenance medication:_______________________________
   ____
4. What symptoms and signs (e.g. nausea, pains, etc.) made you seek medical advice for the condition that led to this hospitalization? ____
5. Date doctor was first seen for this condition: ____
6. On what date/s were you hospitalized for this condition in the past? ______________________________________
7. Name and address of doctor who advised this hospitalization:____
   ____
8. Was he/she the same doctor who treated you at the hospital? ☐ Yes ☐ No ***If not, please give full name and address of the doctor who treated you:***____
9. Have you seen this doctor for ***this illness or for a similar condition in the past?*** ☐ Yes ☐ No
10. Have you seen this doctor for ***any other condition during the past 5 years?*** ☐ Yes ☐ No
    If you have answered YES to either numbers ***9 or 10, please use the attached form for completion by your attending doctor.***
11. Name of the hospital where confined: ____
12. Address of Hospital: ____
13. Date/Time Admitted: ____________________________Date/Time Discharged: _______________________________
14. Witness: ____

I hereby certify that the foregoing information, including any accompanying statements are, to the best of my knowledge and belief, true, correct and complete. I hereby authorize any physician and hospital to furnish and disclose all known facts concerning this disability to Paramount Life & General Insurance Corporation or its representatives. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Insured/Patient: ____ Date: ___________________________