



GROUP HEALTH IN-PATIENT CLAIM FORM

INSTRUCTIONS: The Insured Employee should fill out Part I, either for himself or his dependent and have the Hospital and the Attending Physician fill out Parts III and IV, respectively, on the back hereof. Then this claim statement together with the official statement of account of the Hospital and all other pertinent bills and receipts should be submitted to the Employer. The Employer then should fill out Part II hereof and forward these papers to Generali Life Assurance Philippines, Inc..

TO BE COMPLETED BY THE EMPLOYEE CLAIMING BENEFIT FOR SELF OR DEPENDENT

| | | | | |
|---|------------|------------------------------|-------------------------------|-------------|
| Last Name | | First Name | | Middle Name |
| Date of Birth (MM/DD/YYYY) | | Civil Status | | |
| Present Address | | Business Address | | |
| Email Address | | Bank Account Name and Number | | |
| Occupation | Date Hired | Employed By | Date of Permanent Appointment | |
| Claim is made for: (Check one) | | | | |
| <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Parent <input type="checkbox"/> Son/Daughter | | | | |
| Name of Dependent (Answer only if claim is in behalf of an eligible dependent) | | | | |
| Last Name | | First Name | | Middle Name |
| Date of Birth (MM/DD/YYYY) | | Civil Status | | |
| Is Dependent employed? | | Occupation | | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes , by whom? | | | | |

TO BE ANSWERED ONLY IF INJURY IS DUE TO ACCIDENT

| | | | |
|---|---|----------------------------|-----|
| When and where did the accident happen? Please indicate time. | What was the injured doing when it happened? | | |
| State how it happened? | Was injured person at work when it happened? If so, for whom? | | |
| Maternity Case | Name of Child | Date of Birth (MM/DD/YYYY) | Sex |

I **HEREBY CERTIFY** that the foregoing statements, including any accompanying statement are to the best of my knowledge and belief, true, correct and complete. I certify further that the dependent named above is my eligible dependent. I hereby authorize any physician or any hospital to furnish and disclose all documents and known facts concerning this claim to Generali Life Assurance Philippines, Inc. or to its duly authorized representative.
 In the event of change in benefits which may result in the underpayment or overpayment of claim, I and Generali Life Assurance Philippines, Inc. mutually agree to pay or reimburse the affected party corresponding to the amount involved.

 EMPLOYEE'S PRINTED NAME & SIGNATURE DATE

TO BE COMPLETED BY THE EMPLOYER

| | |
|---|-----------------------|
| Claim is made for <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Parent <input type="checkbox"/> Brother/Sister | |
| If employee is the disabled person please answer A, B and C. | |
| a. When did he stop to work? | Date _____ Time _____ |
| b. When did he return to work? | Date _____ Time _____ |
| c. If not yet back at work, when do you expect him to return? | Date _____ |
| Did disability occur due to occupational cause(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Has claim been filed for employee's compensation commission? <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Will such claim be filed? <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| REMARKS: Please issue reimbursement check in favor of <input type="checkbox"/> Employer <input type="checkbox"/> Employee Named Above | |

I **HEREBY CERTIFY** that the foregoing statements are to the best of my knowledge and belief, true, correct and complete. I certify further that the employee named above is a regular full-time employee of our Company in accordance with our records and insured under our Group Hospitalization Insurance Policy issued to us by Generali Life Assurance Philippines, Inc.
 In the event of change in benefits which may result in the underpayment or overpayment of claim, I and Generali Life Assurance Philippines, Inc. mutually agree to pay or reimburse the affected party corresponding to the amount involved.

 PRINTED NAME OF EMPLOYER'S AUTHORIZED SIGNATORY & SIGNATURE POSITION TITLE DATE

