FPG insurance
MEMBER OF THE ZUELLIG GROUP

NOTIFICATION OF CLAIM

(Original, Detail and itemized invoices must be attached and ALL SECTIONS MUST BE COMPLETED or claim will not be processed.)

PARTICULARS OF CLAIMANT

Patient's Name:	**Policy No.:**
Address:	
Insured's Name if Patient is a dependent:	**Certificate No.:**
If Group Insurance, name of Policyholder:	

AUTHORIZED RELEASE INFORMATION

I hereby authorize the undersigned physician and / or hospital administrator to release any information acquired in the course of my examination or treatment.

_____ Date

_____ Signed (Patient or Parent if a minor)

STATEMENT BY CLAIMANT (By Parent when claimant is a minor)

1. Confidential Detail

Date Admitted _____ mmddyyyy	**Time Admitted** _____ **am / pm**	**Date Discharged** _____ mmddyyyy	**Time Discharged** _____ **am / pm**

2. If as a result of an Accident:

When did accident occur?

Give a brief description of circumtances:

Was this accident reported to the Police? If so, attach Police Report and give details.

Was another party responsible for the injury to yourself? If "Yes" give brief particulars.

3. General

Are you covered for the whole or any of the above expenses by _____

i **Any Social Security System (SSS)?** _____
ii **Any other Medical or Accidental Insurance?** _____
iii **Any other Medical Benefits Scheme?** _____

If "Yes" to any of the above, please state full particulars. _____

4. Declaration

I, the undersigned, declare that the particulars stated on this form are true in every respect. I have supplied full information on all particulars relevant to this claim, and the amounts claimed herein are lawfully due to me under terms, conditions and exceptions of the above numbered policy.

_____ Signature of Person Insured

FPG Insurance Co., Inc.
Zuellig Building 6F, Makati Avenue cor. Paseo de Roxas, Makati City, 1225 Philippines
t (632) 859 1200, 944 1300
f (632) 811 5108
www.fpgins.com

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To be completed by the attending Physician / surgeon only

ATTENDING PHYSICIAN'S RESULT

1. (a) Diagnosis of condition(s) (detailed report) _____

   (b) If confinement in hospital was required, state diagnosis of condition in respect of which hospitalization was required.

   (c) Are any of the conditions treated due to:
   - i) Sickness or injury arising out of the patient's employment? If "Yes" please explain _____
   - ii) Pregnancy? If "Yes" state approximate date of commencement of pregnancy _____

2. (a) When did accident happen or symptoms first appear? _____
   (b) When did patient first consult you for this condition? _____
   (c) To the best of your knowledge, has patient ever had the same or similar conditions or symptoms relating thereto?

3. (a) Name and nature or surgical or obstetrical procedure (if any). Describe fully. _____

   (b) Charge made to patient for (a) above INCLUDING POST OPERATIVE CARE. _____
   (c) State dates of surgical or obstetrical procedures _____
   (d) State dates of
   - i) Out- patient Consultations _____ Number of consultations _____
   - ii) In-patient Visits to bedside _____ Number of visits _____

   (e) If service were rendered in a hospital state name and address of hospital _____

4. Were private nurse services necessary? If "Yes", state for how many days. _____

5. Medical History / Discharge Summary Report

6. To your knowledge does patient have any other health insurance or source of indemnity for his medical costs? If "Yes" please identify. _____

Date	Signature of Attending Physician	Address of Attending Physician