CLAIM FORM

DENGUE, CHIKUNGUNYA AND ZIKA

Part I – DOCTOR'S MEDICAL EVALUATION REPORT
(To be accomplished by the attending physician)

Patient's Name : Sex : Age :

Address :

Nature of Illness :

a. Chief Complaint

b. Final Diagnosis

c. Brief History of Present Illness

Date symptoms first appeared :

Date patient first consulted you for this condition :

Laboratory test / ancillary procedures done and the results :

DECLARATION :

I hereby certify that the statements and facts presented above are true and that I have not withheld any material information in relation to the above condition.

Physician's Signature Over Printed Name

_____

Date : _____ License No. : _____

Contact No. : _____

Part II
(To be accomplished by the assured)

I. If the patient was confined :

Name of hospital _____ Contact No. _____

Address _____

II. For death claim :

Name of Beneficiary : _____ Relationship to assured _____

Claim Settlement Options :

- For Deposit to the Assured's Bank Account
  Account Name : _____ Account No. SA/CA _____
- For Issuance of Check

_____

Assured's Signature Over Printed Name Contact No.: _____ Date Filed : _____

☐ Privacy Consent Statement, I declare that all the information that I provide in this form are mine, true, correct, and updated. By submitting this Claim Form, I authorize and provide my explicit consent to FGEN's Data Processing, Profiling and Sharing provisions as required under Republic Act 10173 and other applicable laws and regulations. I also agree to FGEN's Privacy Policy.

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Insured / Claimant's Signature / Date