redefining / standards

Policy Number

Global Health Access Medical Claim Form

Important Notes:

"We understand that this claim is important to you. In order for us to speed up the process, please (1) Complete this form, (2) Prepare the relevant documents listed on Section 7 and (3) Submit the form to your Financial Executive/Financial Advisor or any AXA Philippines branches.

To enable us to process your claim promptly, please ensure that the form is fully completed. We reserve our rights to request for additional information or documents, if needed.

Please do not sign on blank form. No fees, commission or charges of whatever nature are payable to Agents or Employees of the Company in respect of this claim. Thank you"

FOR OFFICE USE ONLY

Date Received:

Time Received:

Receiving Dept./Office:

FOR DISTRIBUTOR'S USE ONLY

FE/Advisor's code:

FE/Advisor's name:

FE/Advisor's mobile number:

Part I - To be completed by the Policy Owner/Insured.

Please ensure that your signature tallies with the signature that is provided to our Company.

1. Details of the Insured Person

Full Name of Insured (LAST NAME, FIRST NAME, MIDDLE NAME):

Mobile No: (Required)

Email Address: (Required)

2. Claim Details

(a) Symptoms

(b) Date patient first became aware of any signs or symptoms for this condition

(c) Final Diagnosis

(d) Date of consultation

(e) Type of treatment or medicine received

(f) If claim is related to pregnancy, is pregnancy conceived from natural conception? ◯ **Yes** ◯ **No**

3. Accident Claims

Is the medical condition/ injury caused by an accident? ◯ **Yes** ◯ **No**

If "Yes", please tick.

◯ **Road traffic accident** ◯ **Work related accident** ◯ **Others:** _____

Please describe how accident occurred? State date/time of the accident and cause of accident.

Please fully complete all sections in order for us to process your claim.

4. Other Insurance Claims

(a) Do you have other medical plans with other insurance companies/health maintenance organizations (HMOs)? ◯ Yes ◯ No

If "Yes", please state the Policy No., Commencement date and name of Insurer/HMO

(b) Is the treatment covered under Workman's Compensation policy (in the Philippines, these are claims under the Employment Compensation Program)? ◯ Yes ◯ No If "Yes", please state the Policy No., Commencement date and name of Insurer

(c) Has the claim been submitted with the above Insurers? ◯ Yes ◯ No

5. Regular Physician or Family Doctor

Please provide name/s and address/es of the doctor/s consulted in the past 12 months

Name of Doctor or Clinic or Hospital	Address or Telephone number of the clinic/hospital

6. Bank Account Details

Payment will be made in Philippine Peso (PHP) unless we agreed otherwise in writing and bank charges incurred will be borne by the Policyholder/Insured member.

Bank Name

◯ Metrobank ◯ Others: _____

Branch Name/Bank Address

Bank SWIFT Code (for Non-Metrobank)

Account Number of payee:

Account Name of payee:

Preferred reimbursement currency other than Philippine Peso

Declarations and Agreements:

1. I declare that the proceeds of this policy once deposited to the account aforementioned shall be equivalent to payment to me directly of the same and I shall render AXA Philippines ("AXA"), its successors-in-interests and assigns, including its directors, officers, employees and agents, free and harmless from any further claim, demand or action whatsoever, which in law or equity I ever had, now have, or which I, my successors and assigns hereafter may have under this said application/policy.
2. I understand that should the proceeds be credited to a non-Metrobank account, corresponding fees shall be charged to my account.
3. I also understand that if the preferred reimbursement currency not in Philippine Peso, that AXA will reimburse the eligible expenses based on exchange rate determined by AXA. Any exchange costs incurred will be payable by me and will be subtracted from any payment made to me in respect of such a claim.
4. I also take full responsibility in the accuracy of the account name and number indicated above. Should there be any error(s) in the information, I understand that this will result to delays in the crediting of the policy proceeds and I shall bear the consequences.
5. Before signing this declarations and agreements, I have read and understood all declarations and agreements which are hereby given and made willingly and voluntarily and with full knowledge of my rights under the law.

_____

Signature Over Printed Name of the Policy Owner/Insured Person

1. Claim proceeds will only be payable to the Policy Owner or to the Insured Person

2. If the Insured Person is a minor or a minor dependent, proceeds will be payable to the Policy Owner or the Principal Insured Person.

7. Guidelines for document submission

Please tick against the documents you have submitted together with this claim form. We will notify you or your Financial Executive/Financial Advisor/Broker if we need to obtain extra information from you or from other parties to assess your claim. As the time required for obtaining the information varies, the processing time of your claim will likely take longer time.

- ❍ Completed Original Claim form
- ❍ Original final itemized medical bills and proof of payment. (If claiming for cash benefit, copy of itemized final bill is acceptable)
- ❍ Copy of diagnostic test result (Laboratory result, X-Ray, etc), Inpatient discharge summary report
- ❍ Itemized details of the Prescription
- ❍ Copy of final itemized medical bills and Copy of Settlement letter from Insurer/ Employer (if claiming balances from AXA)

If you have any questions regarding this form or any other aspects of the coverage, please contact our **Global Health Access Support Team 24/7 Hotline** at **+(632)5815-207** or **1-800-1888-8292 (AXA)** quoting your Policy Numbers. Claims must be submitted along with all supporting documents within **30 days** from date of treatment.

Send this claim form together with all supporting documents to **AXA Philippines Head Office** or any of AXA's branches nationwide.

8. Declaration and Authorization

I declare that:

1. The information that is disclosed on this claim form is true, complete and accurate, and that no material information has been withheld or is any relevant circumstances omitted.
2. I am not an undischarged bankrupt(s) and I have committed no act of bankruptcy within the last twelve months or received any notification or adjudication order for bankruptcy made against me during that period.
3. I HEREBY AUTHORIZE any employer, registered medical practitioner, hospital, clinic, insurance company, health maintenance organization, bank, government institution, or other organization, institution or person, that has any records or knowledge of the Insured Person _____ _____ with _____ (SSS ID / GSIS ID / Driver's License / Passport Number / Voter's ID /Any Government ID (with photo & signature)) to disclose and make available to AXA Philippines such details and records as may be requested by the Company.
4. The AXA Philippines ("AXA") has a longstanding policy of cooperating with tax and other governmental authorities to combat money laundering, tax evasion or other illegal activities. If I am not a tax resident of the jurisdiction in which the policy, contract or product is issued (a "Cross Border Transaction"), AXA in accordance with applicable laws and regulations, disclose to my home country tax and/or other governmental authorities, my identity and certain information concerning the policy or contract that is the subject of this claim and I hereby consent and agree that AXA, in their discretion, make such disclosure.
5. The information I have provided is my personal data and, where it is not my personal data, that I have the consent of the owner of such personal data to provide such information.
6. By providing this information, I understand and give my consent for AXA and its respective representatives or agents to:
   i. Collect, use, store, transfer and/or disclose the information, to or with all such persons (including AXA or any third party service provider, and whether within or outside of the Philippines) for the purpose of enabling AXA to provide me with services required of an insurance provider, including the evaluating, processing, administering and/or managing of my or our relationship and policy(ies) with AXA, and for the purposes set out in AXA's Privacy Policy which can be found at www.axa.com.ph/legal-disclaimer
   ii. Collect, use, store, transfer and/or disclose personal data about me, the Insured Person and those whose personal data I have provided from sources other than myself for the Purposes.
7. I am happy to receive customer service communication by e-mail and/ or SMS.
8. I am the insured person's parent or guardian if the insured person is under 18 years of age.
9. I further agree that this declaration shall form part of my proposed application for the relevant insurance benefits, and a copy of this form shall be treated as valid and binding as if it were the original.

IMPORTANT: PLEASE DO NOT SIGN ON A BLANK FORM

Signature over Printed Name of Policy Owner

Signature over Printed Name of Insured (if different from Policy Owner)

Date

Part II - To be completed by the Medical Practitioner at the Policy Owner's expense

Important Notes:

1. Part II of this form is to be completed by the Medical Practitioner, except if the claim is for Out-patient claims below PHP 5,000
2. To enable us to process the Insured's claim promptly, please ensure that the form is fully completed.
3. This section need not be completed if the visit is for administration of vaccination.
4. We reserve our rights to request for additional information or documents, if needed.

1. Patient's Details

Full Name of Insured (LAST NAME, FIRST NAME, MIDDLE NAME):

Valid ID Number (SSS/GSIS/TIN/Passport)

Date of Birth (MM/DD/YYYY)

2. Patient's Medical Details

(a) Medical Condition/Diagnosis

(b) ICD Code

(c) Surgical Code

(d) Symptoms Presented

(e) Date of First Time Receiving Treatment (MM/DD/YYYY)

(f) Date of Treatment (MM/DD/YYYY)

(g) If there are symptoms presented, please advise:

(i) how long has the symptom existed prior to consulting you?

(ii) when did the symptoms first start?

(h) If there is no symptom presented, what prompted the patient to consult you?

(i) In your expert opinion, given the aetiology of the condition, how long do you think the condition has been presented?

(j) Type of Investigation (required to confirm the diagnosis). Please attach the reports.

(k) Further treatment plan (if any)

(l) Was the patient referred to you by another Medical Practitioner? ◯ Yes ◯ No
If "Yes", please provide the name of referring Medical Practitioner & contact details.

2. Patient's Medical Details

(m) Does the patient have any related medical condition? ◯ Yes ◯ No
If "Yes, please state and explain the relation.

(n) Does the patient suffer from other significant medical condition(s)? ◯ Yes ◯ No
If "Yes, please state the medical condition(s) and the date of diagnosis.

(o) Did the patient receive any previous consultation/ treatment/ hospitalization for this condition, or associated conditions or symptoms and /or other conditions? ◯ Yes ◯ No

Date of treatment	Medical Condition	Name of Medical Practitioner/ Hospital/ Clinic

(p) Is the condition/ treatment/ surgery related to any of these? ◯ Yes ◯ No
If "Yes", please tick.

- ◯ Pregnancy or childbirth
- ◯ Congenital anomaly
- ◯ Abortion or miscarriage
- ◯ Genetic or chromosomal disorder
- ◯ General health check/screening
- ◯ Infertility or sub-fertility condition
- ◯ Mental or psychiatric condition
- ◯ Sexually transmitted disease
- ◯ Cosmetics reason

(q) Is the medical condition/ injury caused by an accident? ◯ Yes ◯ No
If "Yes", please tick.

◯ Road traffic accident ◯ Work related accident ◯ Others: _____

Please describe how accident occurred? State date/ time of the accident and cause of accident.

(r) For all requests for Pre-Authorization and/or Direct Settlement, please provide the following details:

Treatment Plan/Type of Surgery:				
Estimated Length of Stay:	Room rate per night:	Estimated Hospital Charges:	Estimated Surgeon's Fees: Surgical Fee: Daily Visit:	Estimated Anesthetist's Fees:
Total Estimated Cost for Approval:				

3. Medical Practitioner's Declaration

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection with the above condition and that the facts as given above present my opinion of his/her condition. I declare that the information provided on this form is true and accurate and I did not withhold any material information.

Name of Medical Practitioner

Date

Signature of Medical Practitioner

Hospital/ Clinic Stamp

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Send this claim form together with all supporting documents to **AXA Philippines Head Office** or any of AXA's branches nationwide.