ace insurance

Insurance Company of North America
14th Floor, Export Bank Plaza
Chino Roces Avenue
corner Sen. Gil Puyat Avenue
Makati City 1230
Philippines

+63 (2) 849 6000 *main/claims phone*
+63 (2) 325 1670 *fax*
A&HClaims.PH@acegroup.com *email*
www.aceinsurance.com.ph

Accident and Sickness Proof of Loss Form

IMPORTANT INFORMATION

NOTICE TO INSURED CLAIMANT:

Please answer all questions completely and accurately. Indicate N.A. where question is not applicable.
To enable us to process your claim promptly, please attach the following documents indicated with a '✓' mark.

1. Hospital Income Benefit: ☐ Hospital Discharge Summary ☐ Admitting History ☐ Hospital Statement of Account
2. Medical Reimbursement Benefit: ☐ Original bills and receipts ☐ OR for Surgeon's fees
3. Dismemberment benefit: ☐ Certified copy of Operating Room Record ☐ Official Accident Report (e.g., police report, newspaper clippings, photo)
4. Death Benefit: ☐ Death and Birth Certificate ☐ Autopsy Report ☐ Official Police Report and other related report (e.g., newspaper clippings, photo)
   ☐ Affidavit of Witness ☐ Proof of Relationship to Beneficiary

You will be notified in case additional documents are required.

The issuance and acceptance of this form does not constitute an admission of liability by ACE Insurance or a waiver of its rights.

Part A TO BE COMPLETED BY INSURED

Full name of Insured	

Address of Insured (Please complete this field, as this is where check will be delivered following ACE approval of your claim. Incorrect details may cause delay on check delivery.)

Unit/House No.	Street		
Barangay	Municipality/City	Province	Postcode

Email Address	
Telephone	Home ( ) Business ( ) Mobile ( )
Occupation	
Claim is for	☐ Spouse ☐ Child ☐ Parent ☐ Sibling
Name of claimant	
Claimant's date of birth	/ / Height Weight
Policy number/ certificate	
If group policy, give name of group	
Employer's name	
Employer's address	

DECLARATION AND AUTHORISATION

1. I/We declare that the information contained in this form is true and complete to the best of my/our knowledge and belief.
2. I/We hereby authorize any doctor or any other person who has ever medically attended to the claimant, or any hospital in which he or she has been treated, to disclose any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment to the Insurance Company of North America or their authorised representative.
3. A photocopy of this authorization shall be considered as effective and valid as the original.

Claimant's Signature		Insured's Signature	
Date	/ /		

Note: If the insured is claiming on his or her own behalf, or the claimant concerned is a child under 18 years of age, only the insured's signature is required.

FAILURE TO COMPLETE THIS FORM MAY DELAY PROCESSING/PAYMENT OF YOUR CLAIM.

Part B DETAILS OF CLAIM

If injury, date and time of accident	Date / / Time am / pm
Nature of injury (e.g. fracture, cut, bruise etc.)	

Explain exactly how the accident occurred

If sickness, date symptoms first noticed	/ /

Nature of illness (describe the symptoms suffered)

If hospitalized, name and address of hospital

Period of hospitalization	From / / To / /
Date of first consultation with a medical practitioner for this condition	/ /

What is your physician's or surgeon's name and address?

Details of temporary disability

When did you cease work?	Date / /
If illness, house confinement from	Date / /
When did or will you resume any part of your work?	Date / /
All work?	Date / /
Describe fully the duties of your occupation	

Part C ANY OTHER INSURANCES

Are you claiming from any other insurance company or other sources in respect of injury/illness? Yes ☐ No ☐

If YES, please advise

Name of insurance company
Policy number
Amount of benefits
Date insurance effected

ATTENDING PHYSICIAN'S STATEMENT

Patient's name:

Date of birth: / / Patient's sex: ☐ Male ☐ Female

Primary diagnosis:

Secondary diagnosis:

Confined: From: / / To: / /

Complete admitting history:

Past medical history:

Date of diagnosis:	Medical condition:
/ /	
/ /	

Pertinent physical examination findings:

Significant diagnostic procedure findings:

Date of services:	Place of services:	Description of surgical or medical services rendered/procedure:

Is condition due to injury or sickness arising out of patient's employment? Yes ☐ No ☐

Is condition due to injury or sickness arising out of patient's pregnancy? Yes ☐ No ☐

If YES, approximate date pregnancy commenced: / /

Date symptoms first appeared or accident happened: / /

Date condition was diagnosed: / /

Date patient first consulted you for this condition: / /

Has the patient ever had the same or similar condition? Yes ☐ No ☐

If YES, please state when and provide details:

Is the patient still under your care for this condition? Yes ☐ No ☐

Were registered private duty nurse (R.N.) services necessary? Yes ☐ No ☐

Patient was continuously disabled: From / / To / /

Patient was partially disabled: From / / To / /

Patient was house confined: From / / To / /

If still disabled, date patient should be able to return to work: / /

I hereby certify that I have personally examined and treated the patient for the above injury/sickness and that the facts as given above present my opinion of his/her condition.

Name of Physician: Signature:

Official Address:

Licence No: Telephone:

Date: / / Email:

Partial disablement arises when the claimant is only slightly injured or has so far recovered from injuries as to be capable of attending to some portion of his or her ordinary profession, business or occupation.
Permanent total disability means disablement which, having lasted for at least 12 consecutive months, will, in all probability, entirely prevent the insured person from engaging in gainful employment of any and every kind for the remainder of his or her life.