

Wellness Reimbursement Form

Policy No. _____

INTERNATIONAL HEALTH WELLNESS REIMBURSEMENT FORM (To be accomplished by the Policyowner)

INFORMATION ON THE INSURED

Full Name (Last Name, First Name, Middle Name)	
<input type="text"/>	
Mobile No. (Required)	Email Address (Required)
<input type="text"/>	<input type="text"/>

BENEFIT CLAIMED

Health Screening	Vaccination	Hearing and Visual Aid	Physical Activity Program
Nutrition Counseling	Dental	Others _____	

DETAILS OF THE CLAIM

OR Date	OR No.	Provider	Details	Amount
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

BANK ACCOUNT DETAILS (must be under the name of the policyowner)

Bank Name	Branch
<input type="text"/>	<input type="text"/>
Account Name	
<input type="text"/>	
Co-depositor's Name (if any)	Account No.
<input type="text"/>	<input type="text"/>
Type of Joint Account	<input type="checkbox"/> and <input type="checkbox"/> and/or
Currency	<input type="checkbox"/> Peso <input type="checkbox"/> US Dollar

DECLARATIONS AND AGREEMENTS

1. I/We hereby warrant the truth of the foregoing particulars in every aspect, and agree that if I have made, or if I shall make any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited.

2. I understand that furnishing of this form and other claim forms by the Company does not constitute an admission that there is any insurance inforce nor any liability under the Policy.

3. I declare that the proceeds of this policy, deposited to the declared account, shall render Allianz PNB Life Insurance, Inc., 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.

4. I understand that any corresponding bank charges shall be charged to my account.

5. I 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 hold Allianz PNB Life Insurance, Inc. free from any liability resulting from the erroneous information.

6. Personal information are collected for purposes of validating the identity of the Policyowner and crediting the policy benefit. This document, and all personal information therein, shall be kept for as long as Philippine rules and regulations require, or to defend the Company's claim, if any.

**Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent present or use the same, or to allow it to be presented in support of any claim.

AUTHORIZATION

I/We hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person, government institution or private company or entity that has any record or knowledge, to give to Allianz PNB Life Insurance, Inc. or its representative, any information whatsoever with reference to health, hospitalization, consultation, advice, examination, treatment or ailment, birth, death, marriage, employment and education of the Insured. A photocopy of this authorization shall be as effective and valid as the original.

Printed Name & Signature of Insured	Printed Name & Signature of Policyowner
<input type="text"/>	<input type="text"/>
Date Signed	Date Signed
<input type="text"/>	<input type="text"/>