Allianz PNB
LIFE INSURANCE

Policy No. ☐☐☐ ☐☐☐ ☐☐☐

STATEMENT OF CLAIMANT FOR DISABILITY

Please submit this Claim Form, the written notice of accident and/or hospital confinement, and a Medical Certificate issued by a duly registered Medical Practitioner within thirty (30) days from the date of accident or confinement. No claim shall be considered valid unless the insured is confined in a licensed hospital. Expenses, if any, in securing the Medical Certificate shall be shouldered by the Insured.

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.

INFORMATION ON THE INSURED

Full Name _____

Date of birth _____ Nationality _____ Occupation _____

Address _____

Contact nos. _____ E-mail address _____

DETAILS OF THE ACCIDENT

Date of accident _____ Place of accident _____

Cause of accident (please provide details) _____

_____

Describe the extent of the injury/ies in detail _____

_____

Diagnosis of the Attending Physician _____

Date of return or expected return to work _____

DETAILS OF THE ILLNESS

Describe the nature and symptoms of your illness/disease _____

_____

Date the symptoms first occurred _____

Have you recovered from your illness/disease? _____

What is your present health condition? _____

Have you had this condition or a similar one previously? Please provide details. _____

_____

Indicate which of the following Activities of Daily Living you are currently unable to perform and give date of onset:

- ☐ Ability to feed oneself _____
- ☐ Ability to get in and out of bed _____
- ☐ Ability to move from room to room _____
- ☐ Ability to attend to own toilet needs _____
- ☐ Ability to wash and bathe oneself _____
- ☐ Ability to dress oneself _____

PHYSICIANS

Physician's Name	Clinic/Hospital Affiliations	Contact Nos.

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PRESCRIBED MEDICINES &/OR TREATMENT

Physician's Name, Address & Contact No.	Nature of Injury/Treatment	Prescribed Medicines &/or Treatment

DETAILS OF CONSULTATION/S & HOSPITAL CONFINEMENT/S

Name, Address & Contact No. of Hospital, Clinic or Institution	Attending Physician (Please include Surgeons, if any)	Inclusive Date of Consultation/s and/or Confinement	Nature of Injuries	Procedure/ Operation/s Done (Please give inclusive dates, if any)

Do you have other medical plans with any other insurance company or Health Maintenance Organization (HMO)? ☐ Yes ☐ No

If "Yes", please provide the company name and policy no. _____

Have you filed claims for these benefits with these companies? ☐ Yes ☐ No

DETAILS OF TOTAL & PERMANENT DISABILITY

What was your occupation and designation on the date of the onset of your present disability? _____

What were the activities related to your work, routine functions and/or job description? _____

When was your last day at work? _____ When was your condition diagnosed? _____

When was the onset of your disability? _____

Has your disability existed continuously since then? If not, please explain. _____

What injuries or illnesses have you had prior to your disability? _____

Indicate your level of education (degrees, vocational or technical courses attained) and other occupations for which you are skilled.

Are you presently undergoing or have you undergone therapy sessions? _____

If yes, please provide details on the type of therapy, duration, therapists and improvements noted. _____

OTHER INSURANCE CLAIMS

Do you have other medical plans with any other insurance company or Health Maintenance Organization (HMO)? ☐ Yes ☐ No

If "Yes", please provide the company name and policy no. _____

Have you filed claims for these benefits with these companies? ☐ Yes ☐ No

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BENEFIT PAYMENT OPTIONS
(Does not apply to Waiver of Premium Benefit)

Preferred payout option ☐ Check ☐ Fund Transfer (fill-up Bank Account Details)

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

Bank Name _____ Bank Branch _____

Account Name _____

Co-depositor's Name (if any) _____

Account No. _____

Type of Joint Account ☐ and ☐ and/or Currency ☐ Peso ☐ 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/We understand that furnishing of this form and other claim forms by the Company does not constitute an admission that there is any insurance in force nor any liability under the Policy.
3. I declare that the proceeds of this policy, whether paid in check or 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. If I choose to convert my claim proceeds from Dollar to Peso, they will be paid out based on an exchange rate determined by the Bankers Association of the Philippines, with an additional spread.
6. I take full responsibility for the accuracy of the account details indicated in the Fund Transfer Agreement. Should there be any error(s) in the information, I understand that this will result to delays in the crediting of the claim proceeds and I hold Allianz PNB Life Insurance, Inc. free from any liability resulting from the erroneous information.
7. 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.

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.

That I hereby expressly authorize Allianz PNB Life Insurance, Inc. to obtain, collect, record, organize, store, update, modify, use, share, transfer, disclose and/or destroy ("Process"), whether manually or via electronic channels, any and all information, including personal and sensitive information, about me, the life to be insured, and/or my Policy/ies, to 1) facilitate, monitor and improve the quality of my Policy/ies and such services availed of by me, through programs including but not limited to offer of related products and services, customer satisfaction surveys, and statistical, actuarial and risk analyses, and 2) to comply with legal or regulatory obligations of Allianz PNB Life Insurance, Inc. under applicable local or foreign laws, rules and regulations relating to matters including but not limited to anti-money laundering, and tax monitoring/review/reporting. I also expressly authorize Allianz PNB Life Insurance, Inc. to share, transfer and/or disclose the said information to any of its intermediaries, subsidiaries, affiliates, service providers, partners and government agencies for the said purposes. I likewise promise to inform Allianz PNB Life Insurance, Inc. of any changes relating to my personal information.

I also understand that Allianz PNB Life Insurance, Inc. shall communicate with me primarily via electronic channels, i.e. email, SMS, and mobile and web applications. Policy contracts, official receipts and other similar documents will also be sent to me in electronic format if available.

☐ I prefer receiving communications from Allianz PNB Life Insurance, Inc. in paper format. I understand that the notices, disclosures, and similar documents received through mail and other non-electronic channels might be delayed and I will not hold Allianz PNB Life Insurance, Inc. responsible especially if the delay is due to circumstances beyond its control.

☐ I also expressly authorize Allianz PNB Life Insurance, Inc., to share, transfer and/or disclose my information to any of its subsidiaries, affiliates, and partners for offer for related products and services.

_____ _____
Printed Name & Signature of Insured Printed Name & Signature of Policyowner