The Insular Life Assurance Company, Ltd.
Insular Life Corporate Centre, Insular Life Drive
Filinvest Corporate City, Alabang, 1781 Muntinlupa City
E-mail: headofc@insular.com.ph I Website: www.insularlife.com.ph
Tel.: (632) 8-582-1818 I VAT REG. TIN 000-464-124-000

I-Heal

INSTRUCTIONS TO CLAIMANT:

1. This form (I-Heal Claim Sickness Form I) is to be used if disability is due to sickness and must be completed by the INSURED/ POLICYHOLDER. (If not applicable, please write N/A in the space provided for.)

2. The following must be submitted, along with this form:
   2.1. Hospital's Certification (I-Heal Claim Form II);
   2.2. Physician's Statement (I-Heal Claim – Sickness Form III);
   2.3. Surgeon's Certification (I-Heal Claim Form IV), if surgery was performed; and,
   2.4. All required documents indicated in the above-listed forms.

3. Submit to the Customer Care Unit of The Insular Life Assurance Company, Ltd. located at the above address or to any Insular Life Office.

INSURED'S STATEMENT OF CLAIM
(I-HEAL CLAIM SICKNESS FORM I)

A. Declaration

I hereby submit this claim under my I-Heal policy/ies issued by The Insular Life Assurance Co., Ltd.(Company), numbered as follows:

_____.

All of the following answers and statements are true, complete, and correctly recorded.

I understand that:

1. Issuance of this form and other claim forms by the Company does not constitute an admission that there is any insurance in force.
2. Insular Life shall evaluate the reasonableness of amount of charges and expenses claimed and shall process the claim in accordance with the customary medical expenses and professional fees for the type of disability that I am filing, subject to the applicable policy contract provisions.

INFORMATION ON THE INSURED

Given Name:_____ Surname:_____ Suffix:_____

Mother's Maiden Name

Given Name:_____ Surname: _____

Date of Birth: _____ Place of Birth: _____

Occupation:_____ Gender: _____ Marital Status: _____

Present Address:

House No. | Street | Barangay | Town/Municipality

City/Province | Country | Zip Code

Residence Tel No.	Office Tel. No.	Mobile No.	Email Address

OTHER POLICIES OF INSURED WITH US OR WITH OTHER INSURANCE COMPANIES:

Policy Number	Name of Insurance Company	Amount of Insurance

INFORMATION ON THE POLICYHOLDER (if Insured is different from Policyholder)

Given Name:_____ Surname:_____ Suffix:_____

Date of Birth :_____ Gender:_____

Mother's Maiden Name Given Name:_____ Surname: _____

INFORMATION ON THE ILLNESS

Date first symptoms were discovered: _____

Date of first examination/treatment: _____

Date of confinement: _____

INFORMATION ON YOUR PAST MEDICAL HISTORY (Please answer each question, if not applicable, write N/A)

1. Give names and addresses of other physicians or such person as a herb doctor (herbolaryo), if any, who had attended you for other previous illnesses or diseases or surgery.

Date of Consultations & Treatments			Dates					
Nature of Illness/injury	Name(s) of Attending Physician(s) or Herb Doctor	Address(es) of Attending Physician(s) or Herb Doctor	From			To		
			Mo.	Day	Year	Mo.	Day	Year

2. Name/s of your Family Physician

Name of Physician	Addresses /Contact Numbers

B. Data Privacy Statement

I understand that as a financial institution, Insular Life is subject to existing and future government regulations. I therefore agree to be bound by all applicable domestic and international laws in relation to any matter including but not limited to anti-money laundering, tax monitoring and data privacy.

In this connection, I authorize Insular Life to process my personal and sensitive personal information (also known as personally identifiable information or PII) including the collection, usage, storage, retention, and disclosure of my PII in the related processes and systems until its disposal. I likewise give my consent to Insular Life to share such information to its subsidiaries, affiliates, agents, medical information sharing facility of the insurance industry and third parties for any legitimate purpose, including the underwriting and administration of insurance coverage and claims, marketing and promotion of products, market research, data analytics and automated processing systems, internal and external audits, and such activities for which my PII may be required in fulfillment of mandated services across my entire life stages.

I/We also confirm that I/we have sought the consent of the insured and/or the beneficiary/ies in sharing his/her personal and sensitive personal information, as may be applicable.

I hold Insular Life free and harmless from any liability that may arise from any collection, use, disclosure, destruction or sharing of said information.

C. Authorization

In relation to the claims application for the illness, injury and/or death of the Policy Owner or Insured under this Policy, I hereby authorize The Insular Life Assurance Co., Ltd. ("Company") or its authorized representative to secure any information and/or record belonging to the Policy Owner or Insured, as the case may be, under this Policy pertaining to the following:

1. Financial, employment/business/livelihood;
2. Health, both physical and mental;
3. Lifestyle;
4. Court (criminal, civil or administrative) records;
5. Personal; or
6. Other circumstances

from any of his/her employers, business partners, co-employees, staff, consultants, physicians, or from any hospital, clinic, health maintenance organization, diagnostic center, laboratory or any similar medical facility, any private or government agency or institution, organization, insurance industry association or from any individual person that may have knowledge, access to or custody of any such information or record.

I likewise authorize the foregoing individuals or entities that have/had knowledge, access to or custody of any of the above mentioned information or record to disclose and release the same to Insular Life or its representative and further hereby discharge them from any responsibility, obligation or liability arising out of or in connection with such disclosure and release of the information or record.

Signature of Insured:_____ Date: _____

Signature of Policy Owner: _____ Date:_____

Name and Signature of Witness: _____ Date: _____

Address of Witness: _____

SUBSCRIBED AND SWORN to before me this_____day of_____20___, by the above claimant who exhibited to me his/her government issued ID/Passport No._____, issued at_____on_____.

Doc. No. _____
Page No. _____
Book No. _____
Series No. _____

NOTARY PUBLIC
My Commission expires on _____
Passport No. _____

WARNING: It is unlawful (a) to present or cause to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and (b) to fraudulently prepare, make or subscribe any writing with intent to present or use the same, or to allow it to be presented in support of any claim. Such acts shall be punishable by a fine not exceeding twice the amount claimed or imprisonment of two (2) years, or both, at the discretion of the court. (Section 251, Insurance Code.)