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

Insured's Statement
(I-Shield Claim Form I-A)

INSTRUCTIONS:

1. This form is to be completed (if not applicable, please write N/A in the space provided for) by the INSURED and to be submitted together with the following: Hospital's Certification (I-Shield Claim Form II) and Physician's Statement (I-Shield Claim Form III).
2. The following items should also be submitted and will form part of the I-Shield Claim forms:
   - 2.1 Insured's Hospital records such as, Admitting History, Clinical History and Physical Examination, Discharge Clinical Summary, Results of any Medical Examinations and Laboratory Tests or their equivalent
   - 2.2 Copy of the Police Report,
   - 2.3 Sworn Statement of Witness/es.
3. Submit the accomplished Claim forms together with the item specified above to the Customer Care Unit, The Insular Life Assurance Company, Ltd., Insular Life Corporate Centre, Insular Life Drive, Filinvest Corporate City, Alabang, 1781 Muntinlupa or to any Insular Life District Offices.

A. Declaration:

I hereby make claim under my I-Shield 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 the furnishing of this form and other claim forms by the Company does not constitute an admission that there is any insurance in force.

Part I INFORMATION ON THE INSURED

Name: _____
Surname | Given Name | Suffix (Sr./Jr., etc)

Mother's Maiden Name: _____
Surname | Given Name

Date of birth	Place of birth	Age at time of accident	Sex	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

Your present occupation (if more than one, state all)
Job Title/Position: _____
Brief description of job assignment:

_____
_____
_____

Employer's Name: _____
Employer's Address: _____

_____
Office No. | Name of Street/ Highway | Town/Municipality

_____
City/Province | Country | Zip Code

Nature of Employer's Business:

_____
_____
_____

Do you hold any elective position in government at time of accident?	If yes, please state your position and Title:	Tenure of office:
☐ Yes ☐ No	_____ Position / Title	From: _____ To : _____

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

Policy number	Name of Insurance Company	Amount of Insurance

Part II INFORMATION ON THE ACCIDENT (Please answer each question, if not applicable, write N/A)

1. Date and time of accident

Month Day Year Time

2. Place of accident:

Name of Street/ Highway City or Municipality Province Country

3. Give complete history of the accident or how your injury was sustained:

4. What were you doing before the accident happened? Where were you before the accident? Who was with you before the accident?

5. If you were employed, were you at work at time of accident? If yes, give details:

6. Please answer if claim is due to a vehicular accident

a. During the accident, were you a passenger, driver or pedestrian? _____

b. If driving or riding a motorcycle, were you wearing a helmet? ____Yes____No

c. If driving or riding a vehicle, were you wearing a seatbelt? ____Yes____No

d. Please fill up the following:

If traveling by land	If traveling by plane or ship
Route:_____	Name of Airline/Shipping Company _____
Name of driver :_____	Office Address of Airline/Shipping Company: _____
Vehicle type:_____	_____
Plate number:_____	_____
Registration year:_____	Telephone nos. _____ E-mail address _____
Please attach photo copies of Official Receipt, Certificate of Registration, your Driver's License if you were the one driving (plasticized and renewal receipt of payment).	Please attach a certification from the Airline/Shipping Company stating that you were included in the list of passengers manifest.

7. Was a police investigation conducted on the accident? If yes, please submit certified true copy of the police investigation report and copy (ies) of statement(s) of witness (es). If "No", explain why no such investigation was made.

8. Names, addresses and contact numbers of witnesses to the accident:

Name/s of witness/es	Addresses /Contact numbers

9. Give the names and addresses of the physicians who attended you for the injuries you have sustained from the accident:

Name of physician	Addresses of hospital/clinic	Date of attendance					
		From			To		
		Month	Day	Year	Month	Day	Year

10. If confined in hospital, please provide:

Name of hospital	Addresses	Date of confinement					
		From			To		
		Month	Day	Year	Month	Day	Year

NOTE: PLEASE ATTACH OFFICIAL STATEMENT OF HOSPITAL ACCOUNT AND RECEIPT OF PAYMENT.

If you are no longer confined but still receiving treatment, please state:

a. Where are you being treated? _____

Name of physician _____ Contact numbers : _____

Hospital/Clinic address _____

b. What kinds of treatment are your receiving: _____

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

1. Give the names and addresses of other physicians, if any, who had attended you for other previous illnesses, diseases or injuries during the past two (2) years.

Name/s of Physician	Diagnosis	Name/s & address/es of Hospital/Clinic	Date/s of Consultation/s and Treatment/s					
			From			To		
			Month	Day	Year	Month	Day	Year

2. Names of your family physician

Name/s of physician/s	Address/es and Contact number/s

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 abovementioned 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.)