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

Hospital's Certification
(I-Shield Claim Form II)

INSTRUCTIONS: This form is to be accomplished by the following:

Part 1 - Authorized Officer of the hospital and must be submitted with the official Statement of Account, Official Receipts covering hospital charges incurred during confinement; the patient's Hospital Records such as Admitting History, Clinical History and Physical Examination, Discharge Clinical Summary, Hospital Chart, Clinical Chart Records, or their equivalent
Part II – Attending Surgeon, if surgery was performed and must be submitted together with the Official Receipt covering surgical fee.

Part I To be completed by the hospital's Authorized Representative

Name of Patient: _____
Surname Given Name Suffix (Sr., Jr., etc.)

Date of Birth:	Age:	Sex:	Marital Status:
Nature of Injury:		Diagnosis:	

Complete Name/s of Attending Physician/s:

_____ _____ _____
_____ _____ _____

Dates of Confinement:

Admitted on:

Month Day Year Time

Discharged on:

Month Day Year Time

Period of Confinement:

Room & Board

€ Regular Rooms
From: ___ ___ ___ (Month Day Year) To: ___ ___ ___ (Month Day Year)

€ ICU
From: ___ ___ ___ (Month Day Year) To: ___ ___ ___ (Month Day Year)

Name of Hospital:

Address of Hospital:

No. Name of Street/ Highway Town/Municipality City/Province Country Zip Code

Contact Nos.:	Email address:

Is the hospital registered with the Bureau of Health, Facilities and Services, Department of Health, Phils? ___Yes ____No

If Yes, please indicate : Registration/Permit No. _____Date Issued: _____Issued By: _____

If Not, does it have the permit to operate as hospital,/clinic and to admit in-patient? _____Yes _____No

I HEREBY CERTIFY that the foregoing answers have been taken from the hospital records of the above-named patient. They are true, correct and complete.

Printed Named & Signature of Hospital's Authorized Representative	Official Title	Date Signed

Part II To be completed by the Attending Surgeon, if any surgical operation was performed.

Name of Patient: Last Name First Name Middle Name	Age:	Sex:
Complete Diagnosis:	Short History of Injury:	
Is the patient under your professional care at present? ☐ Yes ☐ No		
Nature of Operation Performed:		
Date Performed:	Where Performed?	
Name of Surgeon:	Fees Charged: P	
Name of Anesthesiologist:	Fees Charged: P	

ATTENDING SURGEON'S DECLARATION

I HEREBY CERTIFY that the foregoing answers in Part II above are true, correct and complete.

Signature of Attending

Date

Area of Specialty

Area of Practice

License No.

Date Issued