Accident and Sickness

Proof of Loss Form

CHUBB®

Important Information

Notice to Insured/Claimant:

Please answer all the questions completely and accurately. Indicate N.A. where question is not applicable.

To enable us to process your claim promptly, please attach the following documents indicated with a " ☐ " mark.

1. Hospital Income Benefit:	☐ Hospital Discharge Summary ☐ Admitting History ☐ Hospital Statement of Account
2. Medical Reimbursement Benefit:	☐ Original bills and receipts ☐ OR for Surgeon's fees
3. Dismemberment benefit:	☐ Certified copy of Operating Room Record ☐ Official Accident Report (e.g., Police Report, newspaper clippings, photo)
4. Death Benefit:	☐ Birth and Death Certificates ☐ Autopsy Report ☐ Official Accident Report (e.g., Police Report, newspaper clippings, photo) ☐ Affidavit of Witness ☐ Proof of Relationship of Beneficiary to Insured

You will be notified in case additional documents are required.

The issuance and acceptance of this form does not constitute an admission of liability by Chubb or a waiver of its rights.

Fraud Warning:
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 cause to 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 to present or use the same, or allow it to be presented in support of any claim.

Chubb A&H Accident & Sickness Proof of Loss Form, Philippines. Published 08/2016.

Part A. To Be Completed By Insured

Full name of Insured _____

Address of Insured (Please complete this field, as this is where the settlement check will be delivered following Chubb's approval of your claim. Incorrect details may cause delay on check delivery.)

Unit/House No. _____ Street _____

Barangay _____ Municipality/City _____ Province _____ Postcode _____

Email Address _____

Telephone Home ( ) _____ Business ( ) _____ Mobile ( ) _____

Occupation _____

Claim is for ☐ Spouse ☐ Child ☐ Parent ☐ Sibling

Name of claimant _____

Claimant's date of birth D D / M M / Y Y Y Y Height _____ Weight _____

Policy number/certificate _____

If group policy, give name of group _____

Employer's name _____

Employer's address _____

_____

_____

Declaration and Authorization

1. I/We declare that the information contained in this form is true and complete to the best of my/our knowledge and belief.
2. I/We hereby authorize any doctor or any other person who has ever medically attended to the claimant, or any hospital in which he or she has been treated, to disclose any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, to Chubb or its authorised representative.
3. A photocopy of its authorization shall be considered as effective and valid as the original.

_____ _____ _____

Claimant's Signature Insured's Signature Date

Note: If the insured is claiming on his or her own behalf, or the claimant concerned is a child under 18 years of age, only the insured's signature is required.

Failure to complete this form may delay processing/payment of your claim.

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Part B. Details of Claim

If injury, date and time of accident Date_____/_____/_____ Time_____am / pm

Nature of injury (e.g. fracture, cut, bruise etc.) _____

Explain exactly how the accident occurred

_____

_____

_____

_____

If sickness, date symptoms first noticed _____/_____/_____

Nature of illness (describe the symptoms suffered)

_____

_____

_____

_____

If hospitalized, name and address of hospital

_____

_____

_____

_____

Period of hospitalization From_____/_____/_____ To_____/_____/_____

Date of first consultation with a medical practitioner for this condition _____/_____/_____

What is your physician's or surgeon's name and address?

_____

_____

_____

_____

Details of temporary disability

When did you cease work? Date_____/_____/_____

If illness, house confinement from Date_____/_____/_____

When did or will you resume any part of your work? Date_____/_____/_____

All work? Date_____/_____/_____

Describe fully the duties of your occupation:

_____

Part C. Any Other Insurance

Are you claiming from any other insurance company or other sources in respect of injury/illness? ☐ Yes ☐ No

If **YES**, please advise

Name of insurance company: _____

Policy number: _____

Amount of benefits: _____

Date insurance effected: _____

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Attending Physician's Statement

Patient's name: _____

Date of birth: ____/____/____ Patient's sex: ☐ Male ☐ Female

Primary diagnosis: _____

Secondary diagnosis: _____

Confined: From: ____/____/____ To: ____/____/____

Complete admitting history:

_____

_____

Past medical history:

Date of Diagnosis	Medical condition:
____/____/____	_____
____/____/____	_____

Pertinent physical examination findings:

_____

Significant diagnostic procedure findings:

_____

Date of services:	Place of services:	Description of surgical or medical services rendered/procedure:
_____	_____	_____
_____	_____	_____

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No

Is condition due to injury or sickness arising out of patient's pregnancy? ☐ Yes ☐ No

If **YES**, approximate date pregnancy commenced: ____/____/____

Date symptoms first appeared or accident happened: ____/____/____

Date condition was diagnosed: ____/____/____

Date patient first consulted you for this condition: ____/____/____

Has the patient ever had the same or similar condition? ☐ Yes ☐ No

If **YES**, please state when and provide details:

_____

_____

Is the patient still under your care for this condition? ☐ Yes ☐ No

Were registered private duty nurse (R.N.) services necessary? ☐ Yes ☐ No

Patient was continuously disabled: From: ____/____/____ To: ____/____/____

Patient was partially disabled: From: ____/____/____ To: ____/____/____

Patient was house confined: From: ____/____/____ To: ____/____/____

If still disabled, date patient should be able to return to work: ____/____/____

I hereby certify that I have personally examined and treated the patient for the above injury/sickness and that the facts as given above present my opinion of his/her condition.

Attending Physician's Statement (continued)

Name of Physician: _____ Signature: _____

Official Address: _____

License No: _____ Telephone: _____

Date: _____/_____/_____ Email: _____

Partial disablement arises when the claimant is only slightly injured or has so far recovered from injuries as to be capable of attending to some portion of his or her ordinary profession, business or occupation.

Permanent total disability means disablement which, having lasted for at least 12 consecutive months, will, in all probability, entirely prevent the insured person from engaging in gainful employment of any and every kind for the remainder of his or her life.

Contact Us

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