FPG insurance

PERSONAL ACCIDENT CLAIM FORM

FORM A

POLICY NO. 1350201180003756

(Please accomplish all sections or claim will not be processed, write N/A if not applicable)

POLICY HOLDER:		
1. Insured's Name (in full):	**DOST – SCIENCE EDUCATION INSTITUTE (GRADUATE SCHOLARS)**	
2. Business Address (in full):	**Science Heritage Building, DOST Complex, Bicutan, Taguig City, Metro Manila**	
3. Telephone No.:	**02-837 1333 / 02-837 2071**	**EXPIRY DATE : AUGUST 25, 2019**

INSURED PERSON		
1. Complete Name		AGE:
2. Occupation (Describe fully)		
3. Complete Address		
4. Is Claimant the Principal Insured?	Yes	No.
a. If **NO**, relation to the Principal Insured:		
5. Is this your First Claim?	Yes	No
a. If **NO**, number of claims filed?		

DETAILS OF ACCIDENT
1. Date and time of Accident:
2. Place of Accident:
3. State precisely how the accident occurred:
4. Was the accident reported or investigated and by whom? ( ) Police ( ) Security Agency ( ) others, please specify: _____ ******Please attach Police/Security Report***
5. Name and Address of Witnesses (if any):

MEDICAL DETAILS		
1. Date first received medical attention:		
2. Name and Address of hospital:		
3. Period of hospitalization:	From:___/___/___	To:___/___/___
4. Period of total inability to carry out usual duties:	From:___/___/___	To:___/___/___
5. Please give details of any physical defects or infirmities:		
6. Please give details of previous injuries with date and periods of incapacity:		
7. Are you entitled to claim compensation for Accident Injury from any other Company / Companies? If so, give particulars:		

AUTHORIZATION

I declare to the best of my knowledge that the above particulars are true and correct.

I hereby authorize any physician, nurse, medical staff, hospital, clinic, organization, institution or individual that has any records or knowledge of _____(insured person's name), to disclose all information pertaining to my health/medical history/claims and to provide copies of all medical records/certifications, including any earlier medical history to FEDERAL PHOENIX ASSURANCE CO., INC in order to process my insurance claims.

FEDERAL PHOENIX ASSURANCE CO., INC may use the above medical information for any and all purposes pertaining to or arising out of claim by the undersigned.

_____ _____

Signature over printed name of Policyholder/Insured

Signature over printed name of the Insured's Person

(Kindly have your Medical Attendant complete Form B)

FORM B

MEDICAL CERTIFICATE

I DO HEREBY CERTIFY that I personally examined the injuries sustained by the above named in the accident described herein, and that the said injuries are as follows:

1. Nature and extent of injuries:		
2. (a) State as fully as possible the cause of the accident: (b) Is the appearance of the injury consistent herewith?		
3. Is there any connection between the present disablement and any disease or previous accident ?_____ If so, please give details: _____		
4. Is surgical interference necessary or likely to become so?	Yes	No.
Please explain briefly. _____		
5. What was your medical management?_____ 6. Is the patient now, or was he at the time of the Accident, subject to or suffering from any illness or disease irrespective of the injury? _____ If so, state (a) the nature of the same, (b) the probable duration thereof, and (c) the extent to which it has affected the patient's recovery.		
7.(a) Has the patient been confined to the house by your instructions?_____ (b) If so, state inclusive dates.	From:___/___/___	To:___/___/___
8. Please state the date when the patient can resume (a) Light work (b) His usual occupation	Date: _____/_____/ _____ Date:_____/_____/_____	
9. When did the patient first consult you for this condition?	Date:_____/_____/_____	

TEMPORARY TOTAL DISABLEMENT

I FURTHER CERTIFY that he has been wholly unable to leave his ('Bed", "Bedroom", "House") and he has been totally disabled by the above Accident Injuries from the _____day of ___, _____,and that he is likely to be disabled for ____from the present time.

TEMPORARY PARTIAL DISABLEMENT

I FURTHER CERTIFY that he has been partially disabled by the above Accidental Injuries from the _____day of _____, _____ and that he is likely to be disabled from _____to the present time.

DATE: _____

SIGNATURE OF ATTENDING PHYSICIAN: _____

ADDRESS: _____

_____

_____

TEMPORARY TOTAL DISABLEMENT – payable when an Insured is totally disabled temporarily from engaging in or giving attention to profession or occupation.

TEMPORARY PARTIAL DISABLEMENT - payable when an Insured is able to attend to some extent of his profession hereof or occupation but unable to attend to a substantial part.