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CLAIM FORM

Date: _____

Member's Name: _____ HPPI ID No.: _____ Effective Dates: _____

Address: _____

Company Name: _____ Member's Telephone No.: _____ Mobile No.: _____

Hospital/Clinic: _____ Attending Physician/s: _____

Availment/Confinement Date/s: _____ Complete Diagnosis: _____

TYPE OF CLAIM

- | | | |
|---|--|---|
| <input type="checkbox"/> Out-Patient | <input type="checkbox"/> Maternity Assistance | <input type="checkbox"/> Accident: <i>Motor Vehicle / Work (encircle)</i> |
| <input type="checkbox"/> Confinement | <input type="checkbox"/> Disability Assistance | <input type="checkbox"/> Others (<i>please state</i>): _____ |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Death Assistance | |

CHECKLIST

Basic:

- Properly filled-up Claim Form
- Original Official Receipts
- Original Statement of Account
- Original Itemized Bill or Charge Slips
- Medical Certificate or Written Doctor's Diagnosis

Maternity Assistance:

- Certified True Copy of Birth Certificate*
- Medical Certificate

Disability

- Certificate of Disability from Attending Doctor
- Copy of Disability Claim (e.g. SSS)
- Certification of Employment

Additional:

- Operation Record (*for operative procedures*)
- Clinical Abstract (*for confinement*)
- Police Report (*for medico-legal cases and accidents*)
- Medico-legal Report *for medico-legal cases and accidents*)
- Incident Report from HR Dept. (*for work-related accidents*)
- Others: _____

Death Assistance:

- Certified True Copy of Death Certificate
- HPPI Membership ID of the Deceased
- Duly Notarized Affidavit of Next of Kin
- Attending Physician's Statement Form / Medical Certificate
- Valid ID of Claimant Next of Kin
- Original Police Investigation Report (*if due to accident*)
- Proof of Relationship

NATURE/CIRCUMSTANCES OF THE CLAIM:

(Please give details/nature/reason for the claim. You may use an additional sheet of paper if necessary.)

(Original Signature of Member above Printed Name)

Note: In order to avoid forfeiture of your claim, please submit/send the properly filled-out Claim Form along with **Complete Supporting Documents** within the **prescribed number of days** to HPPI.