PACIFIC CROSS

NOTIFICATION OF CLAIM
PERSONAL ACCIDENT

ALL SECTIONS MUST BE COMPLETELY FILLED OUT.

A. PARTICULARS OF CLAIMANT

Claimant's Name: _____

Address: _____

Tel. No.: _____ Mobile No.: _____ E-mail Address: _____

Claimant's Date of Birth (dd/mm/yy): _____ Age: _____ Gender: ❑ Male ❑ Female

If claiming under group account, Company/Employer's Name: _____

Describe the illness, injury, or symptom leading to consultation with your doctor: _____

_____

_____

B. AUTHORITY, RELEASE, and DECLARATION STATEMENTS

Authority: I hereby authorize Pacific Cross Insurance, Inc. and/or Pacific Cross Health Care, Inc. and all persons duly authorized and acting in their behalf to request and receive any information or document and record from any hospital, clinic, laboratory, attending physician, and other health service provider, which information or document relates to any medical history, examination, laboratory test results, and/or treatment in connection with this claim, and such other matters related thereto. A photocopy of this is considered an original for all intents and purposes.

Release & Subrogation: Any payment made by Pacific Cross or any payment received by me shall constitute as full, final, and complete settlement of this claim. I further agree that the Company is subrogated to my rights of recovery on all claims and rights of action to the extent of the payments made and/or on account of the losses incurred or which may be incurred by the Company against any person, corporation or entity in connection with this claim. I further agree to authorize the Company to commence all legal actions and proceedings necessary to enforce my claim or recovery thereof with any undertaking to extend my cooperation or assistance whenever necessary.

Non-Waiver Clause For Express Claims: It is understood that the examination/evaluation of the above claim and payment thereof is purely based on the Company's liberality and gesture of promptly and religiously paying the said claim but subject to the condition that any and all future claims arising out of the same condition on the fast-tracked claims should be subject to the Terms and Conditions of the Policy (i.e., limits of the liability, general exclusion, pre-existing conditions, concealed conditions) and the Company, therefore reserves the right to require the Insured to submit documentary proofs in connection thereof.

It is furthermore understood that any payment of a fast-tracked claim shall not be construed as a waiver by the COMPANY to determine the compensability or non-compensability of subsequent/future claims covering the same condition for the fast-tracked claims paid.

Fraud Warning: It is understood that 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 causes 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 to allow it to be presented in support of any claim.

Data Privacy Consent: I understand that Pacific Cross collects and uses my personal data to service and administer my insurance policy, to provide appropriate and timely Medical Services, and for the purposes provided in the Pacific Cross Privacy Statement (available at www.pacificcross.com.ph). By signing this form, I acknowledge that I have read and agree to the terms of the Privacy Statement, and understand that my data may be collected, shared, disclosed, transferred, used or otherwise processed by Pacific Cross in accordance with the Data Privacy Act of 2012, its implementing rules and regulations, and the Privacy Statement. Nothing in this form is intended to revoke or supersede any prior consent that I have given to Pacific Cross in respect of the processing activities involving my personal data.

Declaration: I declare that all particulars stated on all pages of this form are complete and true, whether written by me or by anyone else on my behalf, shall be binding on me, and that the amounts being claimed herein are lawfully due to me under the terms and conditions of the Policy.

_____ _____

Signature over Printed Name of Claimant or of Principal Insured (if Claimant is a Minor) or the Beneficiary (if the Patient/Principal Insured is incapacitated by illness)

Date

Note: For accidental death claims, or for medical claims leading to death, the signatory of this form should be the Claimant's Beneficiary.

OFFICIAL DOCUMENTS SUBMITTED (If space is insufficient, please attach additional details.)

Official Receipt Number	Details of Payment (professional fees, medicines, laboratory exams, etc.)	Amount		
		PHP	USD	Others. Pls. specify currency.
	TOTAL			

For payment processing, please indicate your preferred mode of payment for approved claims:

❑ **DIRECT CREDIT TO MY NOMINATED BANK ACCOUNT**

❑ BDO ❑ Metrobank ❑ BPI ❑ EastWest ❑ UnionBank

❑ Other Banks (except Rural Banks)

Bank and Branch of Account: _____

Bank Address: _____

Account Name: _____

Account No.: _____

Account Type: ❑ S/A ❑ C/A

SWIFT Code: _____

Account Holder's Address: _____

Notes:
1. Whenever applicable, cost of interbranch crediting will be deducted from the approved claim amount.
2. In some cases, nominated banks may deduct fees from the approved claim amount.
3. A processing fee of PHP 100.00 will be deducted from your claim resulting from the incorrect information provided by Claimant.

❑ **GCASH**

❑ If you already have a GCash Card registered to Pacific Cross, please provide the following details:

Account Name: _____

Account Number: _____

❑ If you do not have a GCash Card registered to Pacific Cross yet, please fill out a GCash Registration Form. You may request a copy from our Customer Service Team, or download it from our website.

HEAD OFFICE
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TO BE COMPLETED BY THE MAIN ATTENDING PHYSICIAN/SURGEON ONLY

NOTIFICATION OF IN-PATIENT CLAIM

1. Admitted FROM: _____ TO: _____
2. Complete diagnosis/es of medical condition(s): Month and year when symptoms first appeared:
   a. _____ _____
   b. _____ _____
   c. _____ _____
   d. _____ _____
3. Reason for admission: _____
4. When did the patient first consult you on his/her condition? _____
5. If it is a complication, when did the symptoms start? _____
6. Did the patient's condition require surgery? ❑ Yes ❑ No
   If yes, please state: Surgical procedure done: _____
   Number of in-patient to bedside visits (visits/days): _____
7. Is the condition accident-related? ❑ Yes ❑ No
   If yes: Did the accident cause the patient to be in comatose? _____ For how long? _____
   What were the injuries sustained by the patient? _____
8. Indicate maintenance medication prior to first consult: _____

_____
Signature over Printed Name of the Main Attending Physician/Surgeon

Physician's Address: _____
Physician's Tel. No.: _____

NOTIFICATION OF OUT-PATIENT CLAIM

1. Complete diagnosis/es of medical condition(s): Month and year when symptoms first appeared:
   a. _____ _____
   b. _____ _____
   c. _____ _____
   d. _____ _____

   Surgical procedure done: _____ Place where surgery was performed: _____
2. When did the patient first consult you on his/her condition? _____
3. Is the condition accident-related? ❑ Yes ❑ No
   If yes: Did the accident cause the patient to be in comatose? _____ For how long? _____
   What were the injuries sustained by the patient? _____
4. Is the illness or injury related to the patient's employment? ❑ Yes ❑ No
   If yes, state reason(s): _____
5. Is the illness or injury related to a previous confinement? ❑ Yes ❑ No
   If yes, please indicate confinement date: _____
6. Is the condition maternity related? ❑ Yes ❑ No
   If yes: Patient is pregnant for _____ weeks at consultation.
7. Indicate maintenance medication prior to first consult: _____

_____
Signature over Printed Name of the Main Attending Physician/Surgeon

Physician's Address: _____
Physician's Tel. No.: _____

REMINDER TO PATIENT:

Please refer to the back page (Claims Reimbursement Checklist) for other documents required in filing a claim.

CLAIMS REIMBURSEMENT CHECKLIST

I. FOR IN-PATIENT CLAIMS

BASIC REQUIREMENTS:

- ❑ Duly-accomplished Notification of Claim (NOC) form
- ❑ Original official receipt(s) of all payments made
- ❑ Drug prescription from the attending physician
- ❑ Admitting Medical history (includes detailed history of present illness; family, personal and past medical history)
- ❑ Discharge summary report (includes patient's course in wards, diagnostic tests requested and medications given)
- ❑ Statement of Account (summarized and itemized)
- ❑ Supporting charge slips of statement of account in cases where hospital has no itemized SOA
- ❑ Copy of results of laboratory, X-ray, other diagnostic exams and therapeutic services

If surgical procedure was done:

- ❑ Copy of Operative Report (includes detailed description of surgical procedure done) and Histopathology Report (includes information on the nature, extent and stage of illness which may not be seen in other documents submitted)

For injury as a result of an accident:

- ❑ Basic Requirements for In-Patient claims
- ❑ Copy of police report
- ❑ Incident report

In the event of Death of the Claimant:

- ❑ Copy of Registered Death Certificate

If applicable:

- ❑ Requirements for In-Patient claims
- ❑ Copy of police report

For Overseas claims:

- ❑ Basic Requirements for In-Patient claims
- ❑ Proof of Overseas stay (e.g., airline ticket of the actual flight taken, boarding pass, immigration stamps in the passport or proof of entry and exit tickets where immigration stamps are not applicable)

II. FOR OUT-PATIENT CLAIMS

BASIC REQUIREMENTS:

- ❑ Duly-accomplished Notification of Claim (NOC) form
- ❑ Original official receipt(s) of all payments made (with itemized summary of charges)

If applicable:

- ❑ Copy of the drug prescription from the attending physician
- ❑ Copy of request for laboratory, X-ray, other diagnostic exams and therapeutic services
- ❑ Copy of results of laboratory, X-ray, other diagnostic exams and therapeutic services

In case an Out-Patient operation was done:

- ❑ Copy of Operative Report (includes detailed description of surgical procedure done) and Histopathology Report (includes information on the nature, extent and stage of illness which may not be seen in other documents submitted)

For injury as a result of an accident:

- ❑ Basic requirements for Out-Patient claims
- ❑ Copy of police report
- ❑ Incident report

For Overseas claims:

- ❑ Basic requirements for Out-Patient claims
- ❑ Proof of Overseas stay (e.g., airline ticket, boarding pass or immigration stamps in the passport)

III. FOR BURIAL EXPENSES CLAIMS

BASIC REQUIREMENTS:

- ❑ Duly-accomplished Notification of Claim (NOC) form
- ❑ Original official receipt(s) of all the burial expenses incurred
- ❑ Photocopy of the Death Certificate and relevant Coroner's Report
- ❑ Original Police Report (if the Accident was reported to the police authorities e.g., vehicular Accident)

IV. FOR HOSPITAL INCOME CLAIMS

BASIC REQUIREMENTS:

- ❑ Duly-accomplished Notification of Claim (NOC) form
- ❑ Requirements of In-patient Claims

V. FOR PERSONAL LIABILITY CLAIMS

BASIC REQUIREMENTS:

- ❑ Duly-accomplished Notification of Claim (NOC) form
- ❑ Original official receipt(s) incurred for such liability
- ❑ Any legal document/s establishing that payments have been made by the Claimant to the injured/deceased party, in case the original Official Receipts or bills are not in the name of the Claimant

If applicable:

- ❑ Original Police Report, for other circumstances
- ❑ Other documents deemed necessary by the Company to establish legality of the claim

For Accidental Bodily Injuries to another person:

- ❑ Full Doctor's Report stating details of the Injury treated, Medicines prescribed and the services rendered
- ❑ Original Official Hospital bills and/or Statement of Account

If Death to another person shall have resulted:

- ❑ Photocopy of the Death Certificate and the relevant Coroner's Report

For Accidental Loss or Damage to another person's property:

- ❑ Certification from carrier/hotel/any other office/entity or any proof satisfactory to the Company for the accidental loss or damage to the property

DISCLAIMER: Kindly note that the submission of the above-mentioned documents does not guarantee approval of your claim. Your claim will be reviewed and evaluated based on available documents submitted and subject to the limits and the terms and conditions of your existing Agreement.

Pacific Cross reserves the right to request for additional documents as deemed necessary.

NOTE: If the patient has other medical insurance or healthcare coverage, a certification of Claim Settlement/Payment from other insurer or HMO company must be attached to this Notification of Claim (NOC) form along with all applicable requirements listed herein.