Policy Number(s)

Critical Illness / Disability Claim Form
(Claimant's Statement)

IMPORTANT NOTES

We understand that this claim is important to you. In order for us to speed up the process, please (1) complete this form, (2) prepare the relevant documents listed on Section 1, and (3) submit the complete requirements to your Financial Partner or AXA Service Center.

This form is to be filled out by the Policy Owner. Please do not sign on a blank form. No fees, commissions or charges of whatever nature are payable to Financial Partners or Employees of the Company with respect to this claim.

To be filled out by an AXA personnel

This serves as an acknowledgement receipt and initial advice of claims requirements if initialized.

Date Received:

Time Received:

Receiving Dept./Office:

1. CLAIM REQUIREMENTS

- ❍ Claimant's Statement - duly accomplished and signed by the Policy Owner
- ❍ Attending Physician Statement Form - duly accomplished and signed by the attending physician
- ❍ Complete Medical Records
  - Copy of actual admitting history, discharge summary and/or clinical abstract
  - All laboratory work up results (in-patient or out-patient consultation from clinics or hospitals)
  - Operation technique / operation report if amputation or disarticulation was performed
- ❍ Valid ID of the Policy Owner - submit photocopy(ies)
  - At least one government-issued ID with date of birth, signature, and photo.

NOTE: Claims Department reserves the right to request for any additional documents or proof thereof, as it sees fit.

2. POLICY OWNER'S INFORMATION (Fill out if different from the Insured)

Full Name of Policy Owner *(last name, first name, middle name)*

Please mark whichever applies

❍ Owner ❍ Others (Relationship to insured): _____

Date of Birth *(mm/dd/yyyy)*

Place of Birth

Home Tel. No.

Nature of Work

Mobile Tel. No.

Residence/Present Address

Email Address

3. INSURED'S INFORMATION

Full Name of Insured *(last name, first name, middle name)*

Please mark whichever applies

◯ Owner ◯ Others (Relationship to insured): _____

Date of Birth *(mm/dd/yyyy)*

Place of Birth

Home Tel. No.

Nature of Work

Mobile Tel. No.

Residence/Present Address

Email Address

4. CLAIM DETAILS

What condition / disability are you suffering from?

Please mark the activity/ies that the Insured is currently UNABLE to perform independently:

◯ Ability to feed oneself
◯ Ability to attend to own toilet needs
◯ Ability to get in and out of bed
◯ Ability to move from room to room on level surface
◯ Ability to wash and bathe oneself
◯ Ability to dress oneself

Health History:

Date (mm/dd/yyyy)	Name and Address of the Hospital/Clinic	Diagnosis and Treatment	Doctor's Name	Doctor's Contact Number

5. PAYMENT INSTRUCTIONS

◯ **FUND TRANSFER** (Applicable for both Peso and Dollar policies). Please fill out Direct Credit to Account Section and submit proof of bank account ownership.
Reminder: Fund transfer is only allowed to the bank account of the Policy Owner.

REQUEST FOR DIRECT CREDIT TO BANK ACCOUNT

Account type: ◯ Peso account ◯ Dollar account

Bank Name: ◯ Metrobank ◯ Others:_____

Account Number of Payee:

Branch Name:

Swift Code (for Non-Metrobank)

Account Name of Payee:

Kindly attach on this box the payee's proof of account which can be in the form of the following: deposit slip or screenshot of the bank account number (include the names of the payee and online bank). The account number and name should match the details provided above for validation purposes.

Kindly put a checkmark to ensure that you have completed the necessary requirement on this form:

◯ **I have attached the payee's proof of account which shows the deposit slip or screenshot of the bank account number with the payee's name including the name of the bank using online banking.**

Declarations and Agreements:

1. I declare that the proceeds of this application/policy once deposited to the account aforementioned shall be equivalent to payment to me directly of the same and I shall render AXA Philippines, its successors-in- interests and assigns, including its directors, officers, employees and agents, free and harmless from any further claim, demand or action whatsoever, which in law or equity I ever had, now have, or which I, my successors and assigns hereafter may have under this said application/policy.
2. I understand that should the proceeds be credited to a non-Metrobank account, corresponding fees shall be charged to my account.
3. I hereby declare that the deposit slip or screenshot of online bank I have attached on the proof of account section validates correct information regarding my bank account.
4. I, the undersigned, also take full responsibility in the accuracy of the account name and number indicated above. Should there be any error(s) in the information, I understand that this will result to delays in the crediting of the policy proceeds and I shall bear the consequences.
5. I understand that the information I provided will be validated and authenticated by AXA Philippines.

Signature over printed name of Policy Owner

Date of signing *(mm/dd/yyyy)*

6. AUTHORIZATION

To whom it may concern:

I hereby authorize AXA Philippines and/or its duly authorized representative to secure necessary or relevent information and/or records from any employer, physician, hospital/clinic, other medically related facility, and organization/institution or person, who has records and/or knowledge with regards to sickness and/or injury of _____. I understand that such information will be necessary to process the claim relative to the policy(ies) of the insured.

(Full Name of Insured)

Signature over printed name of Policy Owner

Date of signing *(mm/dd/yyyy)*

7. DECLARATIONS

1. Before signing this Claim Form, I declare that I have carefully read, understood, and agree with all the instructions and questions that are written. I further understand, declare and agree that all statements and answers made in this Claim Form, and all documents attached, are to the best of my knowledge and belief, complete and true, correctly recorded, and shall form part of and be the basis of claim assessment and approval. All the information I provided on this application form are to the best of my knowledge true and correct.

2. Any of my personal information collected or held by AXA Philippines (whether contained in the application/s or otherwise), may be used, stored, disclosed, transferred (whether within or outside the Philippines) to such persons as AXA Philippines may consider necessary, including without limitation but not limited to any of its affiliated or related companies, or any individuals/organizations/corporations/entities associated with AXA Philippines:
   a. to process and deal with my claims request;
   b. to provide all services related to said request; and
   c. to communicate with me for any purpose and/or to comply with the laws of any applicable jurisdiction.

3. I understand that I have the right to access our personal information at any time; correct or rectify any information collected or held by AXA Philippines which are inaccurate, false, or incomplete; object in case of any unauthorized collection; erase or block information which is complete, outdated and false; and such other rights as may be available under the Data Privacy Act. I understand that such request may be made in writing and submitted to AXA Philippines.

4. I understand that notices related to my claim may be sent to me through mail, email or SMS in the address/number I provided above.

Signature over printed name of Policy Owner	**Date of signing *(mm/dd/yyyy)***

8. CONSENT FOR DISTRIBUTOR TO ACCESS INFORMATION (To be filled out by the Policy Owner)

In relation to the claims request of which I am the policy owner, I understand and agree to provide relevant policy information such as but not limited to my name, address, date of birth, place of birth, contact number/information, email address, insured's policy number, claim proceeds, etc. relative to said claim to my distributor:

Name:

for the purpose of claims processing.

I understand that the enumerated policy information will only be used by my distributor for the above purpose and shall be kept by him/her until our transaction has been completed and in accordance with AXA Philippine's Personal Data Retention Policy.

Signature over printed name of Policy Owner

9. Assisting Distributor Declarations

I declare that: 1) I have fully explained to the Policy Owner all relevant information regarding the transactions in this form and 2) the contact details in this form are not my contact number or email address. I also certify that 1) I personally saw the Policy Owner, irrevocable beneficiaries & assignee (if any) affix his/her/their signatures/s in this form and have verified his/her/their identity and 2) I have examined the original ID/s provided and the attached photocopy/ies are true and correct copy/ies of the original ID/s.

Name of Distributor		**Signature of Distributor**
	Code No.	
	Mobile No.	