The Insular Life Assurance Company, Ltd.
Insular Life Corporate Centre, Insular Life Drive
Filinvest Corporate City, Alabang, 1781 Muntinlupa City
E-mail: headofc@insular.com.ph I Website: www.insularlife.com.ph
Tel.: (632) 8-582-1818 I Fax: (632) 8-771-1717 I VAT REG. TIN 000-464-124-000

I-Heal

INSTRUCTIONS TO CLAIMANT: 1. This form (I-Heal Claim - Accident Form III) must be completed by the ATTENDING PHYSICIAN of the Insured. (If not applicable, please write N/A in the space provided for.)

2. The following must be submitted, along with this form:
   2.1. Insured's Statement of Claim (I-Heal Claim - Accident Form I), as applicable;
   2.2. Hospital's Certification (I-Heal Claim Form II);
   2.3. Surgeon's Certification (I-Heal Claim Form IV), if surgery was performed; and,
   2.4. All required documents indicated in the above-listed forms.

3. Submit to the Customer Care Unit of The Insular Life Assurance Company, Ltd. located at the above address or to any Insular Life Office.

PHYSICIAN'S STATEMENT
(I-HEAL CLAIM - ACCIDENT FORM III)

1. Name of Patient: _____
(Given Name) (Surname) (Suffix)

2. Patient's Occupation at time of Accident:

3. Date & Time of Accident

_____
Month Day Year Time

4. Place of Accident _____
Name of Street/Highway City or Municipality Province

5. Date and Place you first attended to the patient? _____
Month/Day/Year Place

6. Describe fully the nature of the injury(ies).

_____
_____
_____
_____

7.1. Was patient, in your opinion, under the influence of liquor, any Intoxicating drink or drug at the time of the accident?

7.2. If he was, what caused you to believe this? Please give particulars.

_____
_____

8.1. Please give full details of nature of treatment/s and/or medical examination/s prescribed to the patient. Include findings, diagnosis and prescribed regimen/remedies

_____
_____
_____

8.2. Please indicate any disease, illness or abnormality that the patient is suffering from independent of the present injury(ies) sustained.

Nature of disease, illness or abnormality	Inclusive dates of illness	If confined, Name and address of Hospital

8.3. Did the patient himself give the above information? If not, please indicate name of resource person and his relationship to the patient?

_____

8.4. Did the abnormality, disease or illness contribute to the occurrence of the accident or retard in any way the patient's recovery from the accident? If so, please provide details

_____

_____

9. Is any surgical operation contemplated in the future? If so please provide details.

_____

_____

_____

_____

10. What is/are your final and complete diagnosis?

_____

_____

_____

_____

11. How long has the patient been under your treatment?

From _____ To _____

Month Day Year Month Day Year

I, _____ hereby certify that the answers given above are full, complete and true.
(Physician's Full Name)

_____
Physician's Printed Name & Signature

License No. : _____
Valid Until : _____

_____
Date Signed

_____
Name and Signature of Witness

_____
Date Signed

SUBSCRIBED AND SWORN to before me this _____ day of _____ 20___, by the above claimant who exhibited to me his/her Govt. issued ID/Passport No. _____ , issued at _____ on _____.

Doc. No. _____
Book No. _____
Page No. _____
Series of _____.

NOTARY PUBLIC
My Commission expires on _____