Generali Life Assurance Philippines, Inc.
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CLAIMANT'S STATEMENT – HOSPITAL INCOME BENEFIT

LIFE INSURED'S INFORMATION

Last Name	First Name		Middle Name	
Address				
Date of Birth (MM/DD/YYYY)	Place of Birth	Nationality	Age	Status
Occupation	Name of Employer	Address		
Contact Details: Home	Cellphone	Fax	E-mail Address	

DETAILS OF PRESENT CONDITION

Date the symptoms were first noticed_____ What were the symptoms?_____

Date of first consultation_____ What was the diagnosis? _____

Date admitted in the hospital_____ Date of Discharge _____

Final diagnosis _____

When are you expected to return to your usual occupation? _____

PLEASE STATE THE NAME AND ADDRESS OF ALL PHYSICIANS INCLUDING MEDICAL INSTITUTIONS WHERE LIFE INSURED HAD RECORD OF CONSULTATION/S AND CONFINEMENT/S:

Date of Attendance	Name of Physician/Address	Medical Institution/Address	Diagnosis/Treatment/Procedure

CLAIMANT'S DECLARATION AND AUTHORIZATION

In my capacity as the Life Insured/claimant of the Policy, I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, entity or employer, having information available as to diagnosis, treatment, results and prognosis, with respect to the physical or mental examination or condition of the insured_____ to give to **GENERALI LIFE ASSURANCE PHILIPPINES, INC., (GLAPI)** or its legal representative, any and all information, or any other information or record it may need to process the claim on the deceased life insured.

The authority herein given pertains to all records containing medical or non-medical data including, but not limited to, mental and dental care, drug or alcohol use, prescribed drugs, information about communicable diseases, and any employment and insurance coverage information.

I also authorize **GLAPI** to obtain an investigative report from its duly authorized inspection agency which will provide any applicable information concerning this claim for insurance benefits on the life of the insured_____.

I agree that a photographic copy of this Authorization shall be valid as the original.

This authorization discharges Generali Life Assurance Philippines, Inc. or any of its authorized representative from any responsibility or obligation in connection with the release of such record or information.

As described above and for that purpose, I attest that the foregoing answers are true and correct and complete to the best of my knowledge and belief.

Dated at _____ this _____ day of _____ 20 _____

_____ _____

SIGNATURE OVER PRINTED NAME OF WITNESS

SIGNATURE OVER PRINTED NAME OF LIFE INSURED/CLAIMANT