PARAMOUNT
DIRECT

HOSPITALIZATION CLAIM FORM

☐ PrimeCARE Cash Plan ☐ Premium HealthCare Plus Plan ☐ HealthCare Cash Plan ☐ Hospital Income Benefit Plan
☐ The Money Shield Plan ☐ Money Shield Plus Plan ☐ Money Plus Plan ☐ Others _____

TO HELP US PROCESS YOUR HOSPITALIZATION CLAIM PROMPTLY,
PLEASE SUBMIT THE FOLLOWING REQUIREMENTS:

1. This Claim Form properly filled out and signed by you on **Part A** and by your attending doctor on **Part B.**
2. Hospital Admitting History and Discharge Summary.
3. Hospital Statement of Account or Certification from the hospital stating time and date/s of confinement.
4. Laboratory and Diagnostic Results.
5. Record/details of operation (if surgical operation was performed).

PART A (To be accomplished by the insured – PLEASE ANSWER ALL QUESTIONS.)

Policyowner's/Patient's Name: _____Policy Number: _____
Address: _____E-mail Address:_____
Name and Address of Employer: _____Tel. No. /Mobile No.: _____
SSS/GSIS Number: _____Other Health Insurance: _____

1. Are you taking maintenance medications? _____What medicines? _____
   _____Since when? _____
2. Name of doctor who prescribed your maintenance medication: _____
3. Address of clinic or hospital of doctor who prescribed maintenance medication:_____
   _____
4. What symptoms and signs (e.g. nausea, pains, etc.) made you seek medical advice for the condition that led to this hospitalization? _____
5. Date doctor was first seen for this condition: _____
6. On what date/s were you hospitalized for this condition in the past? _____
7. Name and address of doctor who advised this hospitalization:_____
   _____
8. Was he/she the same doctor who treated you at the hospital? ☐ Yes ☐ No ***If not, please give full name and address of the doctor who treated you:***_____
9. Have you seen this doctor for ***this illness or for a similar condition in the past?*** ☐ Yes ☐ No
10. Have you seen this doctor for ***any other condition during the past 5 years?*** ☐ Yes ☐ No
    If you have answered YES to either numbers ***9 or 10, please use the attached form for completion by your attending doctor.***
11. Name of the hospital where confined: _____
12. Address of Hospital: _____
13. Date/Time Admitted: _____Date/Time Discharged: _____
14. Witness: _____

I hereby certify that the foregoing information, including any accompanying statements are, to the best of my knowledge and belief, true, correct and complete. I hereby authorize any physician and hospital to furnish and disclose all known facts concerning this disability to Paramount Life & General Insurance Corporation or its representatives. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Insured/Patient: _____ Date: _____

DATA PRIVACY CONSENT STATEMENT

For the purpose of processing my insurance claim on the Insurance Certificate/Policy issued by Paramount Life & General Insurance Corporation (hereafter, "PLGIC"), I hereby consent to:

a. the communication or transmittal of my medical information, medical records, and/or medical history, regarding the illness or injury for which I have been treated, by any physician, clinic or hospital and its authorized personnel, or any other natural or juridical person, to PLGIC, its branches, officers, employees, or agents;

b. the communication or transmittal of my other sensitive personal information in relation to aforementioned illness or injury, by any physician, clinic or hospital and its authorized personnel, or any other natural or juridical person, to PLGIC, its branches, officers, employees, or agents;

c. the processing of the personal data stated above, whether manually or via electronic channels, including but not limited to the collection, usage, storage, recording, customer/client profiling, and disclosure to third parties by PLGIC, its branches, officers, employees, or agents; and

d. the processing of the personal data stated above whether manually or via electronic channels, including but not limited to the collection, usage, storage, recording and customer/client profiling, by authorized third parties for the foregoing purposes.

I further consent that the medical information and/or records provided shall be retained by PLGIC for at least five (5) years or for a longer period if the same is required to be preserved for litigation or to comply with legal or regulatory requirement. I likewise consent to the correction, amendment, deletion and/or disposal by PLGIC and other persons above-mentioned of these information/records which may be inaccurate or incorrect. I attest that I have been made aware of and understood my rights as data subject and how these can be exercised, and that I was informed of the nature, extent and processing of the personal data I provided.

Anti-Fraud Warning

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.

DISCLOSURE: In accordance with the Insurance Commission's Circular Letter No. 2016-54 your medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the Insurance Commission's website at @ www.insurance.gov.ph.

For inquiries or concerns relating to the privacy and security of your personal data or information submitted to Paramount Life & General Insurance Corporation (PLGIC), please contact the office of the Data Protection Officer (DPO) thru the following:

The Data Protection Officer
15th Floor, Sage House Building
110 V.A. Rufino Street, Legaspi Village,
Makati City 1229

E-mail: dataprotectionofficer@paramount.com.ph
Tel. No.: +632 8772 9267
Mobile Nos.: +639176764846

Signature of Insured/Patient: _____ Date: _____

A department of:

PARAMOUNT
LIFE & GENERAL
INSURANCE
CORPORATION