PARAMOUNT
DIRECT

Part B (to be completed by the attending physician)

1. Patient's Name: _____
2. History of illness and concurrent conditions requiring hospitalization: _____
   _____
3. Final Diagnosis: _____
4. Date symptoms of present illness first appeared or accident occurred: _____
5. Date patient first consulted you for this condition or symptoms: _____
6. Results of any X-Ray, ECG, other laboratory tests: _____
7. Any other illness or other impairments to your knowledge? ☐ YES ☐ NO **If YES, please give full details:**
   _____
8. Was any surgical operation performed? ☐ YES ☐ NO **If YES, please give full details:**
   _____
9. Is the patient taking maintenance medications? _____ What medicines? _____
   _____ Since when? _____
10. Name of doctor who prescribed maintenance medication: _____
11. If hospitalization was due to accident, how did the accident occur? _____
    _____
12. Was the patient under the influence of alcohol or drugs on the onset of illness or at the time of the accident?
    ☐ YES ☐ NO **If YES, please give full details:** _____
13. Have you treated or medically advised the Patient in the past? ☐ YES ☐ NO **If YES, please supply the nature of illness or injury and date of consultation / confinement, diagnosis, prognosis and treatment/s given:** _____
    _____
14. Has the Patient consulted any other physician? ☐ YES ☐ NO **If YES, please supply the name of the physician, illness or injury and dates of consultation / confinement, diagnosis, prognosis and treatment/s given:** _____
    _____
15. Dates of Hospital Confinement: From: _____ To: _____
16. Name of Hospital: _____
17. Your Full Name: _____
18. Address of Hospital: _____ Tel No.: _____

I hereby depose and say that the foregoing answers are true and correct to the best of my knowledge including any accompanying statements and there are no material facts in the case which are not disclosed. I hereby authorize the Medical Records of the Hospital mentioned above to furnish Paramount Life & General Insurance Corporation or its authorized representatives any and all information with respect to the sickness or injury, medical history, consultation, treatment and copies of all Hospital medical/clinical records of the aforementioned patient. A photocopy of this authorization shall be considered as effective and valid as the original.

Your Signature: _____ 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

Send this form along with other requirements mentioned to:

11th Floor Sage House, 110 V. A. Rufino Street,
Legaspi Village, Makati City 1229, Philippines
Telefax Number: (02) 8772 9264
Mobile Numbers: 0998 842 1957 • 0917 842 5857