DISABILITY / CRITICAL ILLNESS / MEDICAL REIMBURSEMENT / HOSPITALIZATION CLAIM FORM

BPI AIA

REMINDERS

We understand that this request is important to you. As such, we'd like your transaction experience with us to be meaningful and positive. For an efficient processing of your request, please make sure to:

1) Complete this form and ensure that all the necessary information is provided.
2) Prepare the required documents for your request. You may use the checklist below as a guide on the relevant documents which you will need to submit.
3) Submit the completed form and supporting documents to your **BPI AIA Bancassurance Sales Executive (BSE)** at your preferred BPI or BPI Family bank branch.

To learn the status of your request, you may get in touch with us via the various touch points indicated at the bottom of this page. An update may also be provided to you via SMS or email, as preferred.

PLEASE DO NOT SIGN ON A BLANK FORM. Only one (1) copy of this form is needed for processing. No fees, commission, or charges of whatever nature are payable to employees of BPI AIA in respect of this transaction.

MANDATORY REQUIREMENT/S

WARNING: FILING OF FRAUDULENT CLAIM IS PENALIZED BY LAW

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.

- Claimant Statement (this form) – duly accomplished and signed by the claimant
- Valid ID(s) of the Claimant – preferably government-issued with picture, date of birth and signature; present the actual ID(s) and submit photocopies

OTHER MANDATORY REQUIREMENTS (FOR SPECIFIC CLAIM)

FOR WAIVER OF PREMIUM, DISMEMBERMENT, DISABILITY AND CRITICAL ILLNESS

- Complete Medical Records – include copy of actual admitting history, discharge summary and all laboratory or work up results. In-patient or out-patient consultation from clinics and hospitals should include Operation technique/Operation report if amputation or disarticulation was performed and claiming for accident or disability or waiver of premium
- Attending Physician Statement Form (Critical illness or Disability) - duly accomplished and signed by the Attending Physician

FOR MEDICAL REIMBURSEMENT AND HOSPITAL CONFINEMENT BENEFIT

- Original or Certified True Copy of the Statement of Account (SOA) - in the absence of the SOA, you may submit a Hospital Certification signed by an authorized personnel from the billing or Records Section of the hospital when claiming for Hospital Claim (Medical Expense Benefit)
- Attending Physician Statement Form (Hospitalization or Medical Reimbursement) – duly accomplished and signed by the Attending Physician
- Medical Receipts – if Medical Reimbursement
- Police or Incident Report – if due to an accident
- Certified True Copy of the Operating Room Record - if surgery was performed

TRACKING YOUR CLAIM/REQUEST STATUS

Chat with Bessie, for your policy-related concerns and other questions. Simply go to **https://m.me/BessieofBPIAIA/.**

Send an email to **BPIAIA.CustomerService@aia.com** for your inquiries and feedback.

Talk to a **Bancassurance Sales Executive** at any BPI or BPI Family Savings Bank branch.

Log on to your My AIA account for secure access to your policy requests. Visit **www.bpi-aia.com.ph** today.

Call our customer hotline at **(02) 8528-5501** from Mon.-Fri., 8AM-5PM, except holidays.

Drop by our Vibe Customer Service Center at **GF BPI AIA Makati, 6811 Ayala Avenue, 1226 Makati City.**

DISABILITY / CRITICAL ILLNESS / MEDICAL REIMBURSEMENT / HOSPITALIZATION CLAIM FORM

BPI AIA

DATE (MM/DD/YYYY)
☐☐/☐☐/☐☐☐☐

NOTE: Fill out ☐ with block letters.
Put ☒ on the tick boxes representing options.

POLICY NUMBER

CERTIFICATE NO. (Applicable for Corp. Sol. only)

INDICATE POLICY NUMBERS WHERE THIS CLAIM MAY ALSO BE APPLICABLE:

COMPANY NAME

PART I - GENERAL INFORMATION

NAME OF INSURED/OWNER (Last Name, First Name, Middle Name)

DATE OF BIRTH (MM/DD/YYYY)
☐☐/☐☐/☐☐☐☐

CURRENT OCCUPATION (Please state exact nature)

Tax Identification No. (TIN)

☐ **I am a US Citizen or US Tax Resident with TIN** _____

SEND ME POLICY UPDATES VIA:

MAIL TO HOME ADDRESS (Floor/No., Bldg./Street, Subdivision/Village, Barangay/District, Town/City, Province/State, Country, Zip Code)

CITIZENSHIP

COUNTRY OF RESIDENCE

EMAIL ADDRESS

SMS NOTIFICATION (MOBILE NUMBER)
0 9 ☐☐ - ☐☐☐ - ☐☐☐☐

PART II - TYPE OF CLAIM/S

☐ **HOSPITAL CONFINEMENT BENEFIT**
(provides daily cash benefit while the insured stays in a hospital)

☐ **WAIVER OF PREMIUM**
(waives the policy holder's obligation to pay any further premiums should he become seriously ill or disabled)

☐ **DISABILITY**
(refers to inability or decreased ability of performing the usual duties of one's occupation or activities of daily living due to sickness or accident)

☐ **MEDICAL REIMBURSEMENT**
(a method of payment for medical treatment or hospital costs)

☐ **DISMEMBERMENT**
(loss of a body part or the function of certain body parts)

☐ **CRITICAL ILLNESS**
(a life-threatening condition, which is generally and strictly defined)

PART II-A. IF THIS CLAIM IS DUE TO DISABILITY, PLEASE COMPLETE THIS SECTION

WHAT PARTICULAR DISABILITY IS THE INSURED/OWNER SUFFERING FROM?

Please share below the Activities of Daily Living (ADL) that the Insured/Owner is currently UNABLE to perform without assistance:

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

PART II-B. IF THIS CLAIM IS DUE TO ILLNESS, PLEASE COMPLETE THIS SECTION

CHIEF COMPLAINTS FOR CONSULTATION:

DATE ILLNESS WAS FIRST DIAGNOSED
(MM/DD/YYYY)

DATE SYMPTOMS DISCOVERED/FELT
(MM/DD/YYYY)

DATE OF FIRST CONSULTATION
(MM/DD/YYYY)

PART II-C. IF THIS CLAIM IS DUE TO ACCIDENT, PLEASE COMPLETE THIS SECTION

DETAILS OF INJURY(IES) SUSTAINED:

DATE & TIME OF ACCIDENT
(MM/DD/YYYY)

☐ AM ☐ PM

PLACE OF ACCIDENT

PART III - PAY OUT OPTION

☐ **CREDIT TO MY BANK ACCOUNT** (NOTE: Applicable bank charges may be deducted from the proceeds.)

Account Denomination

☐ **PESO ACCOUNT** ☐ **DOLLAR ACCOUNT**

Bank

Account Name

Account Number

PART III - PAY OUT OPTION

☐ **CLAIM AT ANY BPI / BPI FAMILY BRANCH**
(NOTE: Applicable bank charges may be deducted from the proceeds.)

I certify that I am a Policy Owner of BPI AIA and that I am the owner of the aforementioned bank account number and mobile number and that I can be reached through the mailing address declared in this application. I acknowledge that the payment by BPI AIA of the proceeds of this application through the channel I have designated above, shall release and forever discharge BPI AIA from all actions, claims and demands on all matters involving the said benefit or amount. Further, I certify the correctness and accuracy of the above information I provided BPI AIA and I understand that any discrepancy may cause delay in the disbursement of the proceeds.

CLAIMANT'S SIGNATURE

CO-DEPOSITOR'S SIGNATURE

DATE SIGNED (MM/DD/YYYY)

PLACE SIGNED

PART IV - SIGNATURE

PLEASE DO NOT SIGN ON A BLANK FORM

In consideration of this policy's cash surrender/account value, I/we hereby release and surrender all rights, title, and interest in this Policy unto the BPI AIA and agree to indemnify and protect said Company from all claims and demands under this policy and from all losses, costs, and expenses incident to defending itself against such claims and demands. The liability of BPI AIA which issued this contract is fixed and limited to such cash surrender/account value and any credits, and upon its payment, shall be completely discharged. It is expressly warranted that no other person, partnership or corporation has any interest whatsoever in said Policy and that no insolvency or bankruptcy proceedings are pending for or against the undersigned.

DATA PRIVACY NOTICE. The Company values your privacy and abides by the Principles of Transparency, Legitimate Purpose and Proportionality enshrined in the Philippine Data Privacy Act of 2012. Accordingly, the Company processes, using any medium, any information pertaining to this application or insurance policy and all submitted documents, to provide our insurance and investment products and services. The information and documents are also disclosed to the Company's affiliations (including but not limited to any of its subsidiaries/affiliates in the Asia Pacific Region), its Brokers, Agents, and their employees and staff and to accredited/affiliated third parties or independent/non-affiliated third parties, whether local or foreign. The Company will upload your medical information 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 the said medical 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.

Your information and documents are retained by the Company (a) from execution until seven (7) years after termination of your policy, for hard documents in paper form, and (b) from execution until ten (10) years after termination of your policy, for documents in electronic form; but in no case shorter than may be required by appropriate orders and regulations. Your information will be deleted/destroyed after this period.

The Company will use such information in the insurance policy and all related documents to conduct automated processing, data analytics, profiling, historical research (a) to improve the Company's internal systems and processes, (b) for actuarial assumptions, (c) in internal and external company reports, and (d) to develop and implement business strategies.

I/We hereby authorize any person, organization, or entity that has any record or knowledge of my health and/or that of the insured to give BPI AIA any and all information relative to any hospitalization, consultation, treatment or any other medical advice or examination. This authorization is in connection with the application for reinstatement/policy change/removal or reclassification or rating therefrom. A photographic copy of the authorization shall be valid as the original.

PART IV - SIGNATURE

DATA PRIVACY CONSENT

☐ I/we agree for the Company to use the information in the insurance policy and all related documents in the design and communication of the Company's marketing campaigns and offers in order to improve the quality of service the Company provides, and to receive such marketing campaigns. I/we agree to share the information in the insurance policy with th ird parties for marketing campaigns.

☐ I/we agree for the Company to use such information for profiling to develop, enhance and offer me/us financial services and products that the Company considers as suitable for my/our insurance and other financial needs.

I/we may at anytime withdraw our consent by calling BPI AIA's contact center, or by emailing the request to bpiaia.dpo@aia.com. Upon receipt of such withdrawal of consent, the Company will no longer approach me/us for promotions or products that may be suited to my/our insurance needs. I/We am/are assured that this will not affect the Company's ability to provide quality service in relation to my/our existing policies. Please visit the Company's website, www.bpi-aia.com.ph for our Privacy Statement, which provides further details on why your personal data is collected, how it is intended to be used, to whom your personal data may be transferred to, how to access, review and amend your personal data, and our policies on direct marketing.

Place Signed _____ **Date Signed** (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

_____ _____

CLAIMANT'S NAME IN FULL (Last, First, Middle) **CLAIMANT'S SIGNATURE**

OTHER REQUESTS AND SPECIAL INSTRUCTIONS

TO BE FILLED BY BPI AIA PERSONNEL

If witnessed by an BSE, indicate if: ☐ Original ☐ Reinstating ☐ Assisting/Servicing/Transferred

BSE Signature _____ **BSE Code** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Received by	Branch/Office	Date (MM/DD/YYYY)
Processed by	Branch/Office	Date (MM/DD/YYYY)
Approved by	Branch/Office	Date (MM/DD/YYYY)

Documents submitted together with this application:

NOTES: _____