PNBGen
Inspired to Serve!

PNB GENERAL INSURERS CO., INC.

2nd Floor, PNB Financial Center, Pres. Diosdado Macapagal Blvd. Pasay City

Tel. No.: DL: 832-0311; Trunkline: 891-6040 to 70 Locals: 2109; 2114; 2101; 2103 & 2104

CLAIM INFORMATION SHEET

NOTIFICATION OF CLAIM - TRAVEL INSURANCE

IMPORTANT INSTRUCTIONS:

1. The Claimant must FULLY accomplish the Travel Accident Claim Report Form.
2. For claims processing, all necessary documents have to be submitted. The company reserves the right to request additional documents as deemed necessary.
3. Submission of required documents does not guarantee approval of your claim. The submitted documents will be reviewed and evaluated, subject to the limits, terms and conditions of your existing Travel Policy.
4. This form together with the official receipt(s) must be submitted within a period of not more than 60 days from the date of such claim/loss. Failure of the claimant to submit necessary documents within the given period shall be deemed an abandonment of the claim.

INSURED'S INFORMATION

Insured's Name:		Age:	Sex:
Policy Number:	Address:		
Contact Information:	Home:	Office:	Mobile:
Email Address:			Fax:

CLAIMANT'S INFORMATION

Claimant's Name:		Age:	Sex:
Address:		Birthday:	
		Relationship to Insured:	
Contact Information	Home:	Office	Mobile:

TYPE OF LOSS

PLEASE CHOOSE THE PARTICULAR TYPE OF LOSS:

____ Personal Accident	____ Baggage Delay	____ Trip Curtailment
____ Medical Expenses	____ Flight Delay	____ Loss of Travel Documents
____ Loss/Damage to Baggage	____ Trip Cancellations	____ Others

DETAILS OF INJURY OR SICKNESS

Nature and condition of injury or sickness :	
Place / Address where injury / sickness occurred :	
Hospitalization / consultation dates :	
Name of Hospital / Attending Doctor :	Hospital Address / Contact Number(s) :
Date when patient had any prior treatment of the same illness :	

OFFICIAL RECEIPTS SUBMITTED

Official Receipt (O.R. Number)	Details	Amount

Name of Payee as it should appear on the check : _____

If payee is not the Insured, indicate relationship to the insured : _____

TOTAL AMOUNT CLAIMED : _____ (_____

For processing of payment on approved claims, please indicate bank details for a Direct Credit to your Nominated Bank Account

Bank Account Name :	
Bank Complete Address :	
Bank Account Number :	Bank Account Type :
Relationship to the Patient (If bank account is other than the Patient's) :	

Notes:

1. Applicable only for claim amounts of up to _____ .
2. Check shall be the default mode of payment for approved amount beyond _____.
3. Whenever applicable, cost of inter-branch crediting will be deducted from the approved claim account.
4. A processing fee of _____ will be deducted from your claim resulting from the incorrect information provided by the claimant

ATTENDING PHYSICIAN STATEMENT (If Applicable)

Out - Patient ☐ In - Patient ☐	Date of Admission :
Date of Consultation :	Date of Discharge :
Complete Diagnosis of Medical Condition :	
Do you consider this consultation / hospitalization as a continuous treatment for a chronic disease?	☐ Yes ☐ No
Does the patient have any other disease or infirmity that is affecting his/her present condition?	☐ Yes ☐ No
If YES, please describe :	_____ Attending Physician's Signature over Printed Name

AUTHORITY, RELEASE AND DECLARATION STATEMENT

AUTHORITY : I hereby authorize my travel insurance and / or PNB General Insurers Co. Inc. and its authorized representatives to request and receive any information, document or record from any hospital clinic, laboratory, attending physician and other health service provider, which information or documents relates to any examination laboratory test results, medical history and/or treatment in connection with this claim, and such other matters related thereto.

RELEASE & SUBROGATION : Payment received by me in relation to this claim shall constitute as full, final and complete settlement. I further agree that the Company is subrogated to my rights of recovery on all claims and rights of action to the extent of the payments made and/or on account of the losses incurred or which may be incurred by the Company against any person, corporation or entity in connection with this claim and I further agree to authorize the Company to commence all legal actions and proceedings necessary to enforce my claim or recovery thereof with any undertaking to extend my cooperation or assistance whenever necessary.

DECLARATION : I declare that all data/statements found herein and on all pages of this form are complete and true, whether written by me or by anyone else on my behalf, shall be binding on me, and that the amounts being claimed herein are lawfully due to me under the terms and conditions of the policy.

_____ Signature over Printed Name of Insured / Claimant or of Principal Insured

_____ Date

FOR EVALUATION PURPOSES DO NOT FILL UP

Reference File Number:	CLAIM OUTCOME
EVALUATION :	_____ Approved _____ Denied
	Processed By: _____ SIGNATURE OVER PRINTED NAME
	Approved By: _____ SIGNATURE OVER PRINTED NAME