# Critical Illness Benefit Claim Form

**To be completed by Each Claimant**

Policy Number | | | | | | | | | |

Please properly accomplish this form and provide complete and detailed information. Requests received by FWD service counters within the cut-off time of 2:00 PM will be processed within the day. Requests received beyond cut-off will be processed the next business day.

## 1. General information

Policy Owner Information

| Name of Policy Owner (Title, First Name, Middle Name, Last Name) | | | Date of Birth (mm/dd/yyyy) |
|---|---|---|---|
| Present Occupation | Mobile Number | Email Address | Mailing Address |
| | | | |

Insured Information if different from Policy Owner

| Name of Policy Owner (Title, First Name, Middle Name, Last Name) | | | Date of Birth (mm/dd/yyyy) |
|---|---|---|---|
| Present Occupation | Mobile Number | Email Address | Mailing Address |
| | | | |

## 2. Claimant's statement (Please provide complete and detailed answers to the following questions)

1. State the Critical Illness condition claiming for

2. Describe in details the nature of Insured's condition.

3. If condition is due to Illness

| | |
|---|---|
| a. What are the signs/symptoms experienced? | |
| b. Date the signs/symptoms first experienced | |
| c. How long had you been experiencing these | |
| d. Date you first consulted a doctor | |
| e. What was the Diagnosis? | |

4. If condition is due to accident

| a. Narrate in details how accident happened (include information as to where were you before the accident and what were you doing before the accident) | |
|---|---|
| b. Date and Time of accident | c. Place of accident |

5. Physicians who attended Insured and Hospitals/Clinics where Insured sought consult or was admitted:

| Name of Doctor/s | Name/Address of Hospital/Clinic | Inclusive Date | Diagnosis |
|---|---|---|---|
| | | | |

6. Other illness, disease or injury Insured which suffered from

| Nature of illness or injury and its diagnosis | Treatment or Examination | Hospital / Clinic | Inclusive Date |
|---|---|---|---|
| | | | |

7. Does Insured has any other Insurance Coverage?

| Name of Insurance Company | Policy Number | Amount of Coverage |
|---|---|---|
| | | |

## 3. Pay out option

☐ Check ☐ Credit to my Bank Account *(please fillout details in below box)*

| | |
|---|---|
| Bank: ◯ BPI ◯ BDO ◯ SBC ◯ Metrobank ◯ Others: _____ | Type of Account: ◯ Savings ◯ Checking |
| Account Name: | Account Number: |
| | Branch Name: |
| In this option, I authorize FWD to credit the proceeds to the Bank Account specified above. I certify that I am the owner of the specified bank account and I am the Owner of the FWD Policy Contract bearing the Policy Number indicated in this form. | |

## 4. Declaration and affirmation

I UNDERSTAND AND CONFIRM THAT:

1. The information I have provided above and in any supporting documents and/or records (collectively defined as this 'Form') are true and complete and shall form part and be the basis of the assessment of this request and approval. I understand that providing false, inaccurate or incomplete information may result in my transaction request being denied and shall give FWD the right to cancel the Policy, repudiate the claim or forfeit all payments to be made.
2. The payment by FWD of the benefit or any refund (of premiums or total account value plus insurance charges) as a result of this claim through check or direct credit to the specified bank account number shall release and forever discharge FWD from all actions, claims and demands on all matters involving the benefit, the refund or its amount. Further, I certify the correctness and accuracy of the above information I provided to FWD and I understand that any discrepany may cause delay in the disbursement of the proceeds.
3. In consideration of the payment by FWD of the benefit or any refund (of premiums or total account value plus insurance charges) as a result of this claim, I shall hereby release and waive any and all actions of whatever nature, expected, real or apparent, that I/we have against FWD, its affiliates, subsidiaries, parent or holding companies, their owners, directors, stockholders, executives, officers, employees, and agents, including their assigns and successrs-in-interest in relation to the claim.
4. I hereby declare that I will not institute any action, whether civil, criminal, administrative, and all actions of whatever nature before any court, Insurance Commission or any regulatory body or government agency against FWD, its affiliates, subsidiaries, parent or holding companies, their owners, directors, stockholders, executives, officers, employees, and agents, including their assigns and successors-in-interest in relation to the claim.
5. 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.
6. Data Privacy and Consent Declaration

   By signing and submitting this Form to FWD, I expressly consent to the following:

   a. FWD may collect, use, and store the information provided in this Form to process this request and to service my policies. These shall also be used to update and/or form part of my existing account information and may further be processed and shared for underwriting, reinsurance, policy issuance and administration, claims adjudication, data analytics, historical and scientific research, profiling, risk management, enhancement of products and services, identity verification, protection against fraud, and to comply with legal, regulatory, or contractual requirements. I acknowledge that in certain instances, my information may be processed through automated means.

   b. I understand that FWD reports to its parent company located in Hong Kong and may engage third-party service providers and partners who, in some instances, may be located outside the Philippines. As necessary, my personal and policy information may be processed, shared, stored, and be subject to the laws of these foreign jurisdictions. FWD and its affiliates (FWD Group), third-party service providers and partners, are required to protect the confidentiality of my personal information in a manner consistent with data protection principles.

   c. I authorize FWD to disclose my personal and financial information to FWD Group and any government or tax authority (within or outside the Philippines) for the purposes of ensuring FWD's and FWD Group's continual compliance with applicable laws, regulations, guidelines and good market practices. I aslo agree that FWD has the right to require any of my/our heirs, claimants, assignees and/or
      i. provide FWD with their respective personal and financial information;
      ii. sign and submit such documents as FWD may reasonably require; and
      iii. authorize FWD to disclose such personal and financial information to relevant Filipino and/or foreign government and/or tax authorities.

   d. FWD may contact me to request or clarify information to process this application, send me policy information, and perform other relevant activities to service this policies/request.

   Privacy Policy:
   Your privacy is a priority for FWD. The Company keeps your personal information about you and the products and services you have with us in confidence. For more information and copy of our Privacy Policy, kindly visit our website at https://www.fwd.com.ph/en/privacy-policy/. You may also email our Data Protection Office at dataprotection.ph@fwd.com for any privacy concerns related to your personal information provided to us.

## 5. Authorization

I authorize FWD and/or its duly authorized representative to secure whatever information and/or records from any of Insured's employer, business partners, co-employees, staff, consultants, physician, surgeon, hospital, clinic, other medically related facility, and any private or government agency or organization or institution, insurance industry association or from any individual person, who has any records and/or knowledge or any information with regards to the Insured's health, Illness, sickness, condition, disability and/or injury, hospital confinement including all medical history as described in this Form.

I authorize the said individuals and/or entities that has/have knowledge and access to or custody of any of the records and information regarding Insured's health, Hospital confinement and all medical history to furnish, disclose and release to FWD or its authorized representative. This authorization is in connection with the application for Claims.

I acknowledge and authorize FWD to use any medical and relative information that they have secured or received to process this claims application.

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I have fully read and understood and declare that I voluntary and willingly accomplished this Form with full knowledge of my rights under the law.

This Form shall shall be binding upon my heirs, executors, administrators, legal representatives, successors and assigns.

Place of signing _____ Date: m m / d d / y y y y

_____ Policy Owner's Signature over Printed Name

_____ Insured's Signature over Printed Name

Note: (1) If this form will be signed outside the Philippines, please have the form duly authenticated at the nearest Philippine Embassy or Consulate in your locality. (2) The witness should be a disinterested adult person.

**Please do not sign on blank form**