Hospital Cash Benefit Claim Form

To be completed by Attending Physician

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

1. PATIENT'S AUTHORIZATION

Name of Policy Owner (Tittle, First Name, Middle Name, Last Name)

I hereby authorize any physician, surgeon or other person, organization or entity that has any record or knowledge of my health, Hospital confinement including all medical history to furnish and disclose to FWD or its authorized representative, the Medical Information Bureau or any government agency requiring such. This authorization is in connection with the application for Claims.

Place of signing _____ Date (mm/dd/yyyy) _____

_____ Policy Owner's Signature over Printed Name

_____ Insured's Signature over Printed Name

2. ATTENDING PHYSICIAN'S STATEMENT

To enable us to evaluate the claim for Hospital Cash Benefit, this section must be completed by the Attending Physician providing complete and detailed answers to the following questions:

Association with the Patient

1. Are you the regular physician of the patient? ◉ Yes ○ No
2. Are you related to the patient? If Yes, please state relationship: ○ Yes ◉ No _____
3. How long have you known the patient? _____

General Information

1. When did you first attend the patient for his present condition? (mm/dd/yyyy) _____
2. What are the chief complaints of the patient?

3. What are the signs/symptoms experienced by the patient and date the signs/symptoms were experienced?

Signs/Symptoms	Inclusive Date	Duration it had been present

4. To the best of your knowledge, does the patient had any other illness or impairments? ◉ Yes ○ No
   If Yes, state what are these illnesses/impairments and when were these experience.

Nature of illness, disease or impairments	Inclusive dates of illness	If confined or treated, Name of Clinic/Hospital

5. Please provide other consultations you had with the patient.

Inclusive Dates	For what reason have you attended the patient

6. Please answer by a YES or No

	Yes	No
a. Is the patient's condition a result of attempted suicide or intentionally self-inflicted injury while sane or insane?	○	○
b. Is the nature of injury due to accident or the medical condition a result of drug addiction or alcoholism?	○	○
c. Is the patient's condition caused by HIV or AIDS related?	○	○
d. Is the patient's condition caused by pregnancy, childbirth, miscarriage, abortion or any related complications?	○	○

For any "YES" answer, please provide details below:

7. What was your final and complete diagnosis? (Please include any complications and stage of illness)

3. ATTENDING PHYSICIAN'S AFFIRMATION

This is to certify that the above statements are true and complete to the best of my knowledge and belief.

_____ Attending Physician's Signature over Printed Name

_____ Complete Clinic/Hospital Address

_____ Telephone number / Mobile Number

Lic No: _____
PTR No: _____

_____ Field of Specilalization

_____ Email Address

4. DATA PROTECTION

FWD has appointed a Data Protection Officer to handle any inquiries relating to your personal information. If you would like to obtain a copy of the FWD Life Insurance Corporation Personal Data Policy and Practices, please write to the Corporate Data Protection Officer at 19/F, W Fifth Avenue Bldg., 5th Avenue cor. 32nd Street, Bonifacio Global City, Taguig City 1634, Philippines.

PLEASE DO NOT SIGN ON BLANK FORM