Hospital Cash Benefit Claim Form

To be completed by Each Claimant

Policy Number |_|_|_|_|_|_|_|_|

1. REQUIREMENTS

To process your claim, please submit the following requirements:
(1) Claimant's Statement Form; (2) Attending Physician's Statement Form; (3) Statement of Account; (4) Hospital Records include copy of Admitting History, Clinical Abstract, Discharge Summary, Laboratory and Test results; (5) Government ID with photo and signature.
We may request for additional requirements to further support the processing of the claim as deemed necessary.

Please fill in block letters and the tick appropriate boxes and circles. 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.

2. GENERAL INFORMATION

Policy Owner Information

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

3. CLAIMANT'S STATEMENT (Please provide COMPLETE and detailed answers to the following questions)

1. Confinement Details

Regular Confinement:		ICU Confinement:	
Date Admitted (mm/dd/yyyy)	Date Discharged (mm/dd/yyyy)	Date Admitted (mm/dd/yyyy)	Date Discharged (mm/dd/yyyy)
Name of Hospital:			

2. Reason for Confinement

3. If claim is due to Illness

Physical Complaint/Symptom Experienced	Date the Symptom was first experienced	Duration the symptom was experienced
Date Illness was first diagnosed	Diagnosis	

4. If claim is due to accident

Narrate in details how accident happened	
Date and Time of accident	Place of accident

4. U.S. TAX DECLARATION

1. Are you a citizen, taxpayer, passport holder or green card holder of the U.S. or were born in the U.S.? ☐ Yes ☐ No
   If yes, please provide a copy of your IRS W-Form and the below information:
   U.S. I.D. / Passport no. / Green Card No. ____________________
   U.S. Tax Identification Number / Social Security Number ____________________
   U.S. Permanent residence address ____________________

2. For Corporate Accounts only:
   Do you have a beneficial ownership holding 10% or more or any (direct or indirect) interest by a U.S. citizen, taxpayer, resident or entity? ☐ Yes ☐ No

5. 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.	

6. 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.

7. DECLARATION

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. I authorize FWD and/or its duly authorized representative to secure whatever information and/or records from any employer, any physician, hospital/clinic, other medically related facility, and any organization/institution or person, who has any records and/or knowledge with regard to my or the Insured's Illness, sickness, condition, disability and/or injury as described in this Form.
3. I have fully disclosed all of my citizenships, tax status, residencies, relevant taxpayer identification numbers and agree to notify FWD within thirty (30) days of any changes to the above information. For the purposes of ensuring continued compliance, FWD may request information and/or documents from me including completed, executed and, if necessary, notarized tax declarations or forms.
4. I authorize FWD to disclose my personal and financial information to any government or tax authority (within or outside the Philippines) for the purposes of ensuring FWD's continual compliance with applicable laws, regulations, guidelines and good market practices. I also agree that FWD has the right to require any of my beneficiaries, claimants, assignees and/or payees to:
   a. provide FWD with their respective personal and financial information;
   b. sign and submit such documents as FWD may reasonably require; and
   c. authorize FWD to disclose such personal and financial information to relevant Filipino and/or foreign government and/or tax authorities.
5. The amounts invested in my policies have been declared to the relevant government and tax authorities (within or outside the Philippines) and none were derived, directly or indirectly, from illegal or unlawful activities and sources or from tax evasion. I authorize FWD to withhold payment of any amounts due to myself, my beneficiaries, claimants, assignees and/or payees if required by any relevant government or tax authorities (within or outside the Philippines).
6. The payment by FWD of the proceeds 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 or its amount. Further, I certify the correctness and accuracy of the above information I provided to FWD and I understand that any discrepancy may cause delay in the disbursement of the proceeds.
7. 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.

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

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Policy Owner's Signature
over Printed Name

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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