PROOFS OF HOSPITALIZATION

Submitted to

UNITED COCONUT PLANTERS LIFE ASSURANCE CORPORATION

THIS SECTION TO BE COMPLETED BY CLAIMANT. SUBMIT THIS FORM WITH ITEMIZED DOCTOR'S AND HOSPITAL'S BILLS. TO AVOID UNNECESSARY DELAY IN PROCESSING YOUR CLAIM, ANSWER FULLY EACH QUESTION.

I hereby apply for benefits under my Policy No. _____
for medical/surgical expenses incurred.

1. Name of Insured
a. Single ¤ Married ¤ Widowed ¤
Divorced ¤ Male ¤ Female ¤
b. Occupation
2. Date of Birth _____ _____ at _____
Mo. Day Year Age
3. Does ailment result from occupation of insured? Yes ___ No ___
4. Describe nature of ailment _____
_____
_____
5. Is ailment due to injury? Yes _____ No _____
If "YES", tell:
When it happened _____ 20 _____ at _____
Mo. Day AM/PM
Where it happened _____
How it happened _____
_____
_____
6. If illness, when did it begin? _____ 20 _____
Mo. Day Year
7. Name and address of physician FIRST consulted:
8. Give date of first visit _____ 20 _____
Mo. Day Year
9. Give name and address of your physician and all other physician's treating you for this ailment.
_____
_____
_____
10. Were you PREVIOUSLY confined in a hospital for this ailment? Yes _____ No _____
If "YES", give:
Name of Hospital _____
Date Admitted _____ 20 _____
Mo. Day Year
11. Do you have other hospitalization insurance in force with other insurance companies? Yes _____ No _____
If "YES", give: Date of effectivity _____
Name of Insurance Company _____

DO NOT FORGET TO ATTACH ITEMIZED BILLS

I HEREBY CERTIFY THAT THE FOREGOING ANSWERS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND HEREBY AUTHORIZE ALL DOCTORS OR OTHER PERSONS WHO TREATED ME AND ALL HOSPITALS OR OTHER INSTITUTIONS TO FURNISH FULL INFORMATION (INCLUDING FULL COPIES OF THEIR RECORDS) REGARDING THIS CLAIM.

I FURTHER AGREE THAT THE FURNISHING OF THIS FORM, OR OF ANY OTHER FORMS SUPPLEMENTAL THERE TO, BY THE UNITED COCONUT PLANTERS LIFE ASSURANCE CORPORATION SHALL NOT CONSTITUTE NOR BE CONSIDERED AN ADMISSION THAT THERE WAS ANY OTHER INSURANCE IN FORCE ON THE LIFE OF THE INSURED, NOR ANY WAIVER OF ANY OF ITS RIGHTS TO DEFENSE.

DATE: _____, 20 _____ _____
ADDRESS:_____ SIGNATURE OF INSURED
_____

THIS SECTION TO BE COMPLETED BY THE EMPLOYER:

12. Was claimant employed at the time the disability began? Yes_____ No _____ if "YES", in what capacity was he employed? _____
13. Did injury or illness for which claim is being made arise out of or in the course of occupational employment for wages or profit? Yes _____ No _____
14. Has claim been made for Workmen's Compensation benefits for this disability? Yes _____ No _____
If "YES", is he entitled to such benefits? Yes _____ No _____

	MONTH	DAY	YEAR	TIME
15. Last full day worked:				AM/PM
16. When did employee return to work?				AM/PM
17. If not back at work, when do you expect him/her to return?				AM/PM

_____
Signature of Employer

Position Title: _____
Name of Firm: _____

CLAIMS-013-0417-3

THIS SECTION TO BE COMPLETED BY THE ATTENDING PHYSICIAN:

18. Patient's name _____ Age: _____ Sex _____

19. Give your complete diagnosis:

    a. Tentative _____

    b. Final _____

    List of all complications and contributory Causes _____

20. If surgery was performed, describe operation

    _____

    Where and when was surgery performed? _____ Date _____ 20 _____
    Mo. Day Year

    Surgical Fee Only (Exclude fees for medical calls, anesthesia, etc.) _____

21. List each date you attended patient: at home _____ Total _____ calls @ _____

    at hospital _____ Total _____ calls @ _____

    at office _____ Total _____ calls @ _____

22. Was patient hospitalized? Yes _____ No _____ Name of Hospital _____

    Date of Admission: _____ 20 _____ at _____ o'clock AM/PM
    Mo. Day Yr

    Date of Admission: _____ 20 _____ at _____ o'clock AM/PM
    Mo. Day Yr

23. In your opinion, when did basic cause of condition first originate? _____ 20 _____
    Mo. Day Year

24. In your knowledge, has patient been PREVIOUSLY confined to a hospital for this condition or for a condition due to the same or related cause or causes? Yes _____ No _____
    If answer is "YES", please complete:

Name of Hospital	Date of Confinement	Diagnosis

25. In your opinion is the condition due to injury or illness arising out of employment? Yes _____ No _____
    If answer is "YES", please explain in full _____

    _____

26. Has this disability been serious enough to prevent the patient from working? Yes _____ No _____
    If "YES", please answer the following:

	MONTH	DAY	YEAR	TIME
When was patient first unable to work?	_____	_____	_____	_____AM/PM
If not now prevented from working, on what date could patient have returned from work?	_____	_____	_____	_____AM/PM
If not now able to work, on what date will patient probably be able to work?	_____	_____	_____	_____AM/PM

Date: _____ 20 _____

Address: _____

Physician's Signature: _____M.D.

Physician's Name (In Print) _____

REMARKS:

"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."