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MCC PO Box 1681 * Tel. No. (632) 812-9015 Fax No. (632) 812-9038
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CRITICAL ILLNESS CLAIM FORM

INSTRUCTION: This form shall be accomplished by the Insured/Claimant and must be accompanied by the Attending Physician's Statement and a copy of the itemized hospital billing. The results of tissue specimen, culture (s) and/or titer(s) or other diagnostic studies, which initially diagnosed the specified disease, must accompany your claim.

1. GENERAL INFORMATION

Name: _____ Policy No: _____
Last First Middle

Address: _____
House No./Apt. Street City Province Postal Code

Date of Birth: _____
(MM-DD-YYYY)

Telephone No: _____ Mobile No: _____ E-mail Address: _____

2. CLAIM DETAILS

2.1. Check the corresponding box for the Critical Illness claiming:

❒ Cancer	❒ Encephalitis	❒ Paralysis
❒ Heart Attack	❒ Major Head Trauma with Severe Brain Damage	❒ Fulminant Hepatitis
❒ Stroke	❒ Motor Neurone Disease	❒ Primary Pulmonary Arterial Hypertension
❒ Coronary Artery Bypass Surgery	❒ Heart Valve Surgery	❒ Terminal Illness
❒ End Stage Liver Failure	❒ Poliomyelitis	❒ Apallic Syndrome
❒ Renal Failure	❒ Aortal Surgery	❒ Progressive Scleroderma
❒ Major Organ Transplant	❒ Bacterial Meningitis	❒ Systematic Lupus Erythematosus with Lupus Nephritis
❒ Multiple Sclerosis	❒ Aplastic Anemia	❒ Brain Surgery
❒ Parkinson's Disease	❒ End Stage Lung Disease	❒ Medullary Cystic Disease
❒ Muscular Dystrophy	❒ Coma	❒ HIV Due to Blood Transfusion and Occupationally Acquired HIV
❒ Benign Brain Tumor	❒ Blindness	❒ Loss of Independent Existence
❒ Major Burns	❒ Deafness	
❒ Alzheimer's Disease	❒ Loss of Speech	

2.2. Describe in details the nature of condition.

_____

_____

_____

2.3. Provide details of the following:

Date of first occurrence of signs/symptoms	What are the signs/symptoms experienced?
_____ (MM-DD-YYYY)	
Date of first consultation with a physician	What was the physician's advice?
_____ (MM-DD-YYYY)	

Date of first diagnosis	What is the diagnosis on your condition?
_____ (MM-DD-YYYY)	
The first physician seen was: Full name:_____ Specialty:_____ Address:_____ _____ Phone number: _____	

2.4. Has any relative suffered from a similar or related condition? ❒ Yes / ❒ No

IF YES, please indicate

Relationship	Nature of Illness/Diagnosis	Year Diagnosed	Age at Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2.5. If condition is due to an accident, please provide information of the following:

a. State the nature of the incident: _____

b. Date &Time of accident: _____ | _____ AM/PM (encircle one)
(MM-DD-YY)

c. Place of Accident: _____

d. Narrate completely how the accident happened?

_____

_____

_____

e. Was there police investigation conducted on the accident? ❒ Yes / ❒ No

If yes, please attach the Police Report/Investigation Report and copy/ies of Sworn Statement (s) of Witness (es).

3. PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize any physician, hospital or other institutions having records about the disability/illness that is the basis for my request to make information from these records available to COCOLIFE and its authorized representative. This authorization applies to any dependent on whom a claim is filed. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying Cocolife in writing.

I understand that under Article 175 of the Revised Penal Code using false medical certificate is punishable by law.

Signature of Patient or Representative — Date

_____ _____

Printed Name of Patient or Representative — Representative's Relationship to the Patient (if applicable)

_____ _____

Address of Representative (if applicable)

_____

_____

4. Attending Physician's Statement

Instructions to Physician: The insured identified above is applying for Critical Illness benefit. You should complete and sign the certification below only if you are a doctor of medicine legally authorized to practice in the Philippines and not a relative up to the third degree of the patient above. Provide all requested information and attach additional pages if necessary. Type, print or write in black or blue ink.

1. Are you the patient's usual medical practitioner? ❒ Yes / ❒ No

   How long have you known the patient? _____

2. Diagnosis of the patient's present medical condition. Do not use abbreviations or codes.

   Primary diagnosis: _____ Date: _____

   Secondary diagnosis: _____ Date: _____

   Other diagnosis: _____ Date: _____

3. When did the insured's current medical condition start? _____ Month _____Day_____ Year

4. Nature of medical condition. The medical condition was a result of:

❒ an accident	Give details:
❒ his occupation	
❒ pregnancy, childbirth, abortion, miscarriage, or complication thereof	
❒ a congenital condition	
❒ psychiatric condition	
❒ use of alcohol, drugs, narcotics not prescribed by a medical doctor	
❒ other predisposing medical illness	
❒ hereditary, genetic, familial predisposition	

5. Please check the condition that applies to this patient and provide the test results, operative reports, pathology reports, and/or your detailed medical statements as required for the condition indicated below:

(Check all that apply)

❒ Cancer	❒ Encephalitis	❒ Paralysis
❒ Heart Attack	❒ Major Head Trauma with Severe Brain Damage	❒ Fulminant Hepatitis
❒ Stroke	❒ Motor Neurone Disease	❒ Primary Pulmonary Arterial Hypertension
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❒ Major Burns	❒ Deafness	
❒ Alzheimer's Disease	❒ Loss of Speech	

Please check the attached medical records:

❒	Medical abstract	❒	Imaging study: angiogram, angioplasty, CTA/MRA of the heart, X-ray, ultrasound, CT scan, MRI, PET scan
❒	Discharge summary	❒	Operation Technique Form
❒	Histopathologic report	❒	Blood exam
❒	Others, specify:		

I certify that I have personally examined the physical condition of the patient individual and that I have answered the questions truthfully and to the best of my knowledge and belief. I understand that under Article 174 of the Revised Penal Code, issuing false medical certificates of any physician or surgeons is punishable by law.

SIGNATURE OF PHYSICIAN Date

_____ _____

PHYSICIAN NAME AS IT APPEARS IN THE PRC LICENSE:

_____

LAST NAME FIRST NAME MIDDLE NAME

REGISTRATION NO. (PRC ID NUMBER): _____

VALID UNTIL: _____

BUSINESS ADDRESS: (NO. STREET/ CITY OR TOWN/ PROVINCE/ ZIP CODE)

_____

_____

TELEPHONE/CELLPHONE: _____

SPECIALTY/SUBSPECIALTY: _____

Privacy Information Cocolife recognizes the importance of protecting you and your patients' personal information, and is committed to complying with its privacy law obligations.

"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."