FPG insurance
MEMBER OF THE ZUELLIG GROUP

PERSONAL ACCIDENT CLAIM FORM

FORM A

(Please accomplish all sections or claim will not be processed, write N/A if not applicable)

POLICY HOLDER

1. Insured's Name (in full):	
2. Business Address (in full):	
3. Telephone No.:	

INSURED PERSON

1. Complete Name		AGE:
2. Occupation (Describe fully)		
3. Complete Address		
4. Is Claimant the Principal Insured?	Yes	No
a. If **NO**, relation to the Principal Insured:		
5. Is this your First Claim?	Yes	No
a. If **NO**, number of claims filed?		

DETAILS OF ACCIDENT

1. Date and time of Accident:
2. Place of Accident:
3. State precisely how the accident occurred:
4. Was the accident reported or investigated and by whom? ( ) Police ( ) Security Agency ( ) others, please specify: _____ ***Please attach Police/Security Report
5. Name and Address of Witnesses (if any):

MEDICAL DETAILS

1. Date first received medical attention:		
2. Name and Address of hospital:		
3. Period of hospitalization:	From:____/____/____	To:____/____/____
4. Period of total inability to carry out usual duties:	From:____/____/____	To:____/____/____
5. Please give details of any physical defects or infirmities:		
6. Please give details of previous injuries with date and periods of incapacity:		
7. Are you entitled to claim compensation for Accident Injury from any other Company / Companies? If so, give particulars:		

AUTHORIZATION

I declare to the best of my knowledge that the above particulars are true and correct.
I hereby authorise any physician, nurse, medical staff, hospital, clinic, organization, institution or individual that has any knowledge of _____ (insured person's name), to disclose all information pertaining to my health/medical history/claims and to provide copies of all medical records/certifications, including any earlier medical history to FPG Insurance Co., Inc in order to process my insurance claims.
FPG Insurance Co., Inc may use the above medical information for any and all purposes pertaining to or arising out of claim by the undersigned.

_____
Signature over printed name
of Policyholder/Insured

_____
Signature over printed name
of Insured's Person

(Kindly have your Medical Attendant complete Form B)

FPG Insurance Co., Inc.
Zuellig Building 6F, Makati Avenue cor. Paseo de Roxas, Makati City, 1225 Philippines
t (632) 859 1200, 944 1300
f (632) 811 5108

Federal Phoenix Assurance Co., Inc.
www.fpgins.com

FPG insurance
MEMBER OF THE ZUELLIG GROUP

FORM B

MEDICAL CERTIFICATE

I HEREBY CERTIFY that I have personally examined the injuries sustained by the insured person in the accident described herein, and that the said injuries are as follows:

1. Nature and extent of injuries:		
2. Final Diagnosis:		
3. Is the patient now, or was he at the time of the Accident, subject to or suffering from any illness or disease irrespective of the injury?		
If so, state (a) the nature of the same, (b) the probable duration thereof, and (c) the extent to which it has		
affected the patient's recovery.		
4. Is there any connection between the present disablement and any disease or previous accident ?		
If so, please give details:		
5. Is surgical interference necessary or likely to become so?	Yes	No
Please explain briefly.		
6. What was your medical management?		
7.(a) Has the patient been confined to the house by your instructions?		
(b) If so, state inclusive dates.	From:____/____/____	To:____/____/____
8. Please state the date when the patient can resume (a) Light work	Date: ____/____/____	
(b) His usual occupation	Date: ____/____/____	
9. When did the patient first consult you for this condition?	Date: ____/____/____	

TEMPORARY TOTAL DISABLEMENT

I FURTHER CERTIFY that insured has been wholly unable to leave his ('Bed", "Bedroom", "House") and he has been totally disabled by the above Accident Injuries from the _____day of _____, _____,and that he is likely to be disabled for _____ from the present time.

TEMPORARY PARTIAL DISABLEMENT

I FURTHER CERTIFY that insured has been partially disabled by the above Accidental Injuries from the _____ day of _____, _____ and that he is likely to be disabled from _____ to the present time.

DATE: _____

NAME AND SIGNATURE OF ATTENDING PHYSICIAN: _____

_____

ADDRESS: _____

_____

_____

TEMPORARY TOTAL DISABLEMENT – payable when an Insured is totally disabled temporarily from engaging in or giving attention to profession or occupation.

TEMPORARY PARTIAL DISABLEMENT - payable when an Insured is able to attend to some extent of his profession thereof or occupation but unable to attend to a substantial part.