InLife Benefits
formerly Generali Life Assurance Philippines, Inc.

InLife Benefits Insurance Company, Inc.
10th Floor Petron Mega Plaza, Makati City Philippines 1209
P +632 8888 0808 | TIN 203-028-895-000
inlifebenefits.com.ph

GROUP HOSPITALIZATION CLAIM STATEMENT

INSTRUCTIONS: The Insured Employee should fill out Part I, either for himself or his dependent and have the Hospital and the Attending Physician fill out Parts III and IV, respectively, on the back thereof. Then this claim statement together with the official statement of account of the Hospital and all other pertinent bills and receipts should be submitted to the Employer. The Employer then should fill out Part II thereof and forward these papers to InLife Benefits Insurance Company, Inc.

TO BE COMPLETED BY THE EMPLOYEE CLAIMING BENEFIT FOR SELF OR DEPENDENT

Last Name		First Name	Middle Name
Date of Birth (MM/DD/YYYY)		Civil Status	
Present Address		Business Address	
Occupation	Date Hired	Employed By	Date of Permanent Appointment
Claim is made for: (Check one) ☐ Self ☐ Spouse ☐ Brother/Sister ☐ Parent ☐ Son/Daughter			
Name of Dependent (Answer only if claim is in behalf of an eligible dependent) Last Name		First Name	Middle Name
Date of Birth (MM/DD/YYYY)		Civil Status	
Is Dependent employed? © No ☐ Yes , by whom?		Occupation	

TO BE ANSWERED ONLY IF INJURY IS DUE TO ACCIDENT

When and where did the accident happen? Please indicate time.	What was the injured doing when it happened?		
State how it happened?	Was injured person at work when it happened? If so, for whom?		
Maternity Case	Name of Child	Date of Birth (MM/DD/YYYY)	Sex

I HEREBY CERTIFY that the foregoing statements, including any accompanying statement are to the best of my knowledge and belief, true, correct and complete. I certify further that the dependent named above is my eligible dependent. I hereby authorize any physician or any hospital to furnish and disclose all documents and known facts concerning this claim to InLife Benefits Insurance Company, Inc. or to its duly authorized representative.

In the event of change in benefits which may result in the underpayment or overpayment of claim, I and InLife Benefits Insurance Company, Inc. mutually agree to pay or reimburse the affected party corresponding to the amount involved.

EMPLOYEE'S PRINTED NAME & SIGNATURE DATE

TO BE COMPLETED BY THE EMPLOYER

Claim is made for ☐ Employee ☐ Spouse ☐ Son/Daughter ☐ Parent ☐ Brother/Sister
If employee is the disabled person please answer A, B and C. a. When did he stop to work? Date_____ Time _____ b. When did he return to work? Date_____ Time _____ c. If not yet back at work, when do you expect him to return? Date _____
Did disability occur due to occupational cause(s)? © No © Yes
Has claim been filed for employee's compensation commission? © No © Yes
Will such claim be filed? © No © Yes
REMARKS: Please issue reimbursement check in favor of ☐ Employer ☐ Employee Named Above

I HEREBY CERTIFY that the foregoing statements are to the best of my knowledge and belief, true, correct and complete. I certify further that the employee named above is a regular full-time employee of our Company in accordance with our records and insured under our Group Hospitalization Insurance Policy issued to us by InLife Benefits Insurance Company, Inc.

In the event of change in benefits which may result in the underpayment or overpayment of claim, I and InLife Benefits Insurance Company, Inc. mutually agree to pay or reimburse the affected party corresponding to the amount involved.

PRINTED NAME OF EMPLOYER'S AUTHORIZED SIGNATORY & SIGNATURE POSITION TITLE DATE

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TO BE COMPLETED BY THE HOSPITAL'S AUTHORIZED REPRESENTATIVE ONLY IF THE HOSPITAL STATEMENT OF ACCOUNT CANNOT PROVIDE THE DATE HEREIN

NOTICE TO HOSPITAL: To expedite settlement of the claim, please answer all questions herein and attach your official statement of account duly signed together with all other bills and/or receipts, prescriptions covering all hospital charges including medicines incurred during confinement.

Name of Patient	Date of Confinement Admitted on Date_____ Time _____
Name of Hospital	Discharged on Date_____ Time _____
Is this hospital/ clinic registered with the Bureau of Medical Services? ⓞ No ☐ Yes	If not, does it have a permit to operate as a hospital/ clinic and to admit patients? ⓞ No ⓞ Yes

HOSPITAL CHARGES

	Incurred	Medicare Charges
Room & Board		
Ward___days	P _____	P _____
S/Private___days	P _____	P _____
Private___days	P _____	P _____
Other Hospital Charges		
Operating/Delivery Room	P _____	P _____
Anesthesia	P _____	P _____
Laboratory	P _____	P _____
ECG, BMR, etc	P _____	P _____
X-ray	P _____	P _____
Drugs, Medicines, etc.	P _____	P _____
Dressings	P _____	P _____
Oxygen/ blood Transfussions	P _____	P _____
Diatherymy, Physical therapy, etc	P _____	P _____
Nursery	P _____	P _____
Others	P _____	P _____
TOTAL	P _____	P _____

Has this bill been paid? (If yes, attach official receipt) ⓞ No ⓞ Yes

I HEREBY CERTIFY that the foregoing answers have been taken from the hospital records of the above-named patient. They are true, correct and complete.

PRINTED NAME AND SIGNATURE | OFFICIAL TITLE | DATE

Hospital Address _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

Name of Patient	Age	Sex	Complete if surgery was performed	
Complete Diagnosis			a. Nature of operation/ obstetrical performed	
Short history of illness or disability			b. Date performed	
			c. Where performed	
Did disability or illness arise out of and in the course of patient's employment? ☐ Yes ⓞ No (If so, explain briefly.)			d. Name of Surgeon	Fee charged
Is this patient under your professional care at present? ⓞ Yes ⓞ No			e. Anesthesiologist	Fee charged
If the confinement is due to pregnancy, give approximate date of first day of last menstruation			Remarks	

I HEREBY CERTIFY that the foregoing answers are true, correct and complete.

PRINTED NAME & SIGNATURE OF ATTENDING PHYSICIAN | LICENSE NO. | DATE