STARR INSURANCE COMPANIES

CRITICAL ILLNESS INSURANCE CLAIM FORM

STARR INTERNATIONAL INSURANCE PHILIPPINES BRANCH is committed in protecting your personal data privacy. Presented below is an overview of our practices in careful handling of your personal information.

GATHERING
Starr gathers your personal information (which may include sensitive information) in order to establish all necessary details that will assist us in the proper handling and evaluation of your claim. Personal information may be obtained by us directly from you or via a third party such as your insurance intermediary (i.e. agent or broker) or employer (in case of group insurance policy).

When the information is provided to us via third party, we use that information on the basis that you have consented or would reasonably expect us to collect your personal information in this way and ensure that you will be made aware on our practices in handling your personal information.

USE
The main purpose for our collection and use of your personal information is to make sure that appropriate and fair evaluation of claim will be delivered to you in accordance with the terms, conditions and provisions of your insurance policy. All reasonable precautions are carefully taken to protect this personal information and being treated with utmost confidentiality.

DISCLOSURE
We may disclose the information we collect to third parties, including service providers engaged by us to undertake certain claims procedures such as investigation and verification on our behalf. In some circumstances, we may need to transfer personal information to other entities within the STARR Group of Companies (such as our offices in Hong Kong, USA and other countries) or third parties with whom we, or those other STARR Group entities, have sub-contracted to provide specific services for us which may be outside of the Philippines.

In all instances where personal information may be disclosed overseas are for claims related only, in addition to any local data privacy laws, all reasonable precautions are carefully taken and strict measures are in place to ensure that those parties hold and use that information in accordance with the consent you have provided and in accordance with our responsibilities to you under the DATA PRIVACY ACT OF 2012.

Please be informed that you have an option to withdraw your consent by providing us your written notice. However, it is important for you to understand that this may mean that we may not be able to respond favorably to any claim. For data privacy concerns, please reach us at dpo.ph@starrcompanies.com

FRAUD WARNING
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 (IC Circular No. 2016-50).

IMPORTANT INFORMATION
a. Please complete the claim form in BLOCK CAPITALS and fill-up all the required information in this form truthfully and accurately. If the space is not enough or no applicable field is available, please supplement information by attaching a separate sheet;
b. Acceptance of this form must not be construed as an admission of liability on the part of Starr International Insurance Philippines Branch;
c. We may require submission of additional document/s, as needed.

SECTION A: POLICYHOLDER AND INSURED PERSON INFORMATION

Policy No.:	Name of Policyholder / Insured:	
Policy Period:	Insured's Address:	
Date of Birth:	Sex: ☐ Male ☐ Female	E-mail Address:
Employer:	Occupation:	Date of Employment:
Insured's Contact Nos.:	*If different from Policyholder/Insured:* Name of Claimant and Relationship to Insured	Contact Nos.:

SECTION B: TYPE OF CLAIM AND AMOUNT

☐ Critical Illness: Please specify _____	☐ Dietary and Nutritional Therapy	Total Claim Amount (please specify currency):
☐ Cancer Surgical Treatment	☐ Home Accessibility Benefit	

SECTION C: DETAILS OF ILLNESS AND TREATMENT

Symptoms:	Date when symptom first appeared:	Date of consultation:
Name of Attending Doctor:		Name & Address of the Hospital:
Final Diagnosis:		Date Admitted: _____ Date Discharged: _____
Have you been diagnose or treated before of the said illness? ☐ No ☐ Yes, please indicate when and where (hospital name)		Have you been taking medication for the said illness? ☐ No ☐ Yes, please indicate when and how long

SECTION D : OTHER INSURANCE			
Do you have other insurance policies covering this loss or expenses incurred? ☐ No ☐ Yes, please provide below information.			
Name of Insurer:	**Policy Number:**	**Policy Period:**	**Benefit & Sum Insured:**

SECTION E : DECLARATION AND AUTHORIZATION

- The undersigned hereby declares that to the best of my/our knowledge and belief, the above statement and particulars are fully and truly made;
- I/We agree that if any fraudulent means or devices are used in connection with obtaining any benefit under the Policy, the Policy shall be void against me/us;
- I/We agree that any of my/our personal information collected or held by Starr International Insurance Philippines Branch ("STARR") or its authorized representatives is provided and will be held, used and disclosed by STARR to individuals/organization associated with STARR or any selected third party for the purpose of processing the claims herein, providing data matching and to communicate with me/us for such purposes. The undersigned understand that STARR may not be able to process the claims herein if I/we fail to provide any information requested in this Claim Form. The undersigned further understand that I/we have the right to obtain access and to request correction of my personal information held by STARR. Such request can be made to STARR's Operations Officer-In-Charge at Unit 5, Tower 2, 23/F, The Enterprise Center, 6766 Ayala Avenue corner Paseo de Roxas, Legaspi Village, Makati City, Philippines.
- I/We hereby irrevocably authorize STARR or its authorize representative to obtain my/our medical records from my/our treating physicians, hospitals, clinics, insurance companies, government agencies or other relevant organizations in relation to the accident or claim. This authorization is valid even I/we am/are deceased. My/our next of kin is also bound by this authorization. The original or copy of this authorization has the same effects.

I hereby agree and authorize Starr International Insurance Philippines Branch to pay benefit due in respect of this claim to:

(Please indicate Payee Name in full as per Bank Account in BLOCK CAPITALS)

Signature of Insured Person/Claimant:

Date Signed: _____

In the event that the claim is covered and payable under the policy, please indicate PREFERRED MODE OF PAYMENT:

- ☐ Check for pick-up
- ☐ Bank Deposit (please provide Bank Details)
  - Bank Account Name _____
  - Bank Name / Branch _____
  - Bank Account Number _____

DOCUMENTARY REQUIREMENTS

For us to proceed with our evaluation of your claim, please **accomplish** and **submit** this **Claim Form** together with the supporting documents enumerated below

1. INCIDENT REPORT OR POLICE REPORT (if Critical Illness was due to accident)
2. VALID IDENTIFICATION CARDS OF THE INSURED / CLAIMANT
3. PROOF OF RELATIONSHIP TO INSURED (if Insured is a Minor)
4. ADMISSION AND DISCHARGE SUMMARY OR CLINICAL ABSTRACT
5. COMPLETE HOSPITAL RECORDS AND MEDICAL REPORTS (including but not limited to the following)
   - Type of Critical Illness diagnosed and certified by a Registered Medical Practitioner
   - Previous Consultation and/or Confinement Records
   - Diagnostic Results (including APE), if available
   - History Sheet containing chief complaint, personal and family history
   - Laboratory and work-up tests results
   - Recommendation and assessment of the attending Registered Medical Practitioner
6. OPERATIONAL PROCEDURE AND SURGICAL METHOD (for cancer surgical treatment)
7. HOSPITAL BILLS AND MEDICAL RECEIPTS
8. PICTURES AND OFFICIAL RECEIPTS
9. IN CASE OF DEATH;
   - Death Certificate
   - Proof of Beneficiary - PSA Certified Birth Certificate/Marriage Certificate/ CENOMAR with two (2) valid IDs of the beneficiary
   - For Minor Beneficiary – Copy of grant of guardianship, if applicable

NOTE: *Insurer reserves the right to request for additional documents they may find necessary. Such request for documentation shall not be construed as an admission of liability on our part but rather to aide us in our evaluation.*

FOR ANY ENQUIRIES, PLEASE SEND ALL YOUR CORRESPONDENCE TO:

Starr International Insurance Philippines Branch
Unit 5, 23/F, Tower 2, The Enterprise Center
6766 Ayala Avenue corner Paseo de Roxas,
Legaspi Village, Makati City 1226, Philippines
Phone: (632) 8689-6639; 8689-6603; 8689-6632
e-mail: claimcare.ph@starrcompanies.com

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SECTION F : MEDICAL REPORT (TO BE COMPLETED BY ATTENDING PHYSICIAN)

Name of Patient:		Date of Birth:
Date of First Consultation:	Was the patient referred to you by another doctor? ☐ No ☐ Yes, please indicate Name and Address of Referral Doctor.	

What symptom(s) did the patient complain about?	According to the patient, how long has he/she been experiencing these symptoms?
To the best of your knowledge, has the patient ever had the same or similar condition(s)? ☐ No ☐ Yes, please describe condition _____	Excluding this event how long has the patient been in your care?
Was the condition caused by a pre-existing condition and/or any underlying disease? ☐ No ☐ Yes, please specify _____	What was your final diagnosis?

Are you the patient's primary care doctor?

☐ No
☐ Yes, please specify who _____

Discharge Summary (including investigation procedures, result, diagnosis, treatments, complications, therapy and follow-up plan):

Please describe all laboratory test and procedures conducted for the patient.

Name of Hospital/Clinic:	Date of Admission:	Date of Discharge:
Address of Hospital/Clinic:	Phone No. & Fax No.:	e-mail Address of Attending Physician:

PLEASE READ BEFORE SIGNING: I hereby certify that I have personally examined and treated the above patient for the above described injury and that the facts as given above present my opinion of his/her condition.

Name of Attending Physician/Specialist: Qualification: _____	Signature & Stamp of Attending Physician/Specialist:	Date Signed: