STARR
INSURANCE COMPANIES

PERSONAL ACCIDENT 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
1. 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;
2. Acceptance of this form must not be construed as an admission of liability on the part of Starr International Insurance Philippines Branch;
3. We may require submission of additional document/s, as needed.

SECTION A: POLICYHOLDER AND INSURED PERSON INFORMATION

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

SECTION B: TYPE OF CLAIM AND AMOUNT

☐ Accidental Death / Disablement	☐ Accidental Burns Benefit	☐ Accidental Medical Expenses	Total Claim Amount (please specify currency):
☐ Accidental Death Burial Expenses	☐ Accidental Common Carrier Benefit	☐ Others please specify): _____	

SECTION C: DETAILS OF ACCIDENT

Date & Time of Accident:	Place of Accident:
Circumstance of Loss (please briefly describe the chronology of the accident):	
Name of Witness and relationship to the Insured	Contact No. and e-mail address of the Witness:

SECTION D: NATURE OF INJURY

Describe in details the injuries sustained, indicating the body part injured and the type of the injury sustained (i.e. cut, fracture, swollen):

Has the same part of your body been injured before? ☐ No ☐ Yes If yes, please describe briefly _____

Name & Address of Doctor who treated you:	Name & Address of the Hospital where you were treated:
Consultation Dates : _____	Date Admitted : _____ Date Discharged : _____
Name & Address of your usual Family Physician:	Date returned/expected to return to work:

For Disability affecting hand/fingers, please check appropriate box:

☐ Left- Handed ☐ Right-Handed

SECTION E : 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 F : 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, 23rd Floor, Tower 2 The Enterprise Center, 6766 Ayala Avenue corner Paseo de Roxas, Legaspi Village, Makati City 1226 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:	For Group Policy Only Signature of Policyholder's Authorized Representative (please indicate full name and position):
Date Signed: _____	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 _____

ATTACHMENTS/DOCUMENTARY EVIDENCE

Please provide the following details and submit the original medical receipts enumerated below. Please use a separate sheet if necessary.

No.	Date	Receipt No.	Description of Expense	Currency	Amount Claimed	Mode of Payment
				TOTAL		

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

Name of Patient:	Date of First Consultation	Admitting Diagnosis

Is condition due to Injury or Sickness?

- ☐ Sickness
- ☐ Accident on _____

Was the patient referred to you by another doctor?

- ☐ No
- ☐ Yes, please indicate Name and Address of Referral Doctor. _____

Of what symptom(s) did the patient complain?

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 _____

Was the condition caused by any underlying disease?

- ☐ No
- ☐ Yes, please specify _____

What was your final diagnosis?

Did Injury result in fracture of bones?

- ☐ No
- ☐ Yes, please specify _____

Will the current condition(s) or symptom(s) result in permanent disability?

- ☐ No
- ☐ Yes, please specify _____

Is the patient suffering, had suffered or been diagnosed to have Osteoporosis?

- ☐ No
- ☐ Yes, please describe condition _____

Do you think the injuries sustained would have prevented him from working?

- ☐ No
- ☐ Yes, how many days (approximately)? _____

Is there any other factor that may have caused the occurrence of the accident?

- ☐ No
- ☐ Yes, please specify_____

Is there a special treatment prescribed to the patient?

- ☐ No
- ☐ Yes, please specify_____

Is the current condition or symptom related to burn injury?

- ☐ No
- ☐ Yes, please specify _____

Is the patient recommended for further medical treatment in the future?

- ☐ No
- ☐ Yes, please specify _____

For Burns, please indicate degree and percentage of affected body surface

Is the degree of burn on the parts of the body will result to its disability?

- ☐ No
- ☐ Yes, please specify_____

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

Name of Hospital/Clinic:	Date of Admission:	Date of Discharge:
Address of Hospital/Clinic:	**Phone No. & Fax No.:**	**Email 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:

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To facilitate processing of your claim, please submit the **Duly Accomplished Personal Accident Claim Form** together with the required supporting documents listed below. We reserve the right to request for additional information or document, if necessary.

ACCIDENTAL PERMANENT DISABILITY; BURNS BENEFIT; ACCIDENTAL MEDICAL EXPENSES & COMMON CARRIER BENEFIT:

1. Original copy of Incident Report
1. Original copy of Investigation Report issued by the competent authorities with findings on the alleged accident;
2. Original copy of all medical invoices, hospital bill, statement of account and official receipts / proof of payments;
3. All hospital & medical records detailing the diagnosis and treatment received;
4. Medical specialist report on sustained permanent disability, if applicable:
5. Copy of at least two (2) valid government IDs with three (3) specimen signatures;
6. Copy of Driver's License if driving at the time of the accident;
7. Photograph of insured (in amputation cases).
8. Proof of Relationship (if the Insured is Minor)
9. Copy of Shipping Line, Plane or Bus Tickets, Car / Taxi Receipts or the likes, if available

ACCIDENTAL DEATH AND BURIAL BENEFIT:

1. Original copy of Investigation Report issued by the competent authorities with findings on the alleged accident;
2. Original copy of all medical invoices and receipts;
3. All hospital & medical records;
4. Medical specialist report certifying death;
5. Copy of at least two (2) valid government IDs of the deceased;
6. Copy of Driver's License if driving at the time of the accident;
7. Certified True Copy or PSA Certified Death Certificate;
8. Original copy of Official Receipts for Burial Expenses;
9. PSA Certified Copy of Birth Certificate of the Insured
10. Proof of Beneficiary
    a. IF MARITAL STATUS OF DECEASED IS SINGLE:
    ✓ PSA Certified True Copy of Certificate of No Marriage:
    ✓ PSA Certified True Copy of the Marriage Certificate of the Surviving Parents;
    ✓ Copy of the Valid Government ID of Both Surviving Parents;
    b. IF MARITAL STATUS OF THE DECEASED IS MARRIED:
    ✓ PSA Certified True Copy of the Marriage Certificate;
    ✓ Copy of the Valid Government ID of the Surviving Spouse;
    ✓ Copy of Birth Certificate of Surviving Children
    c. IF SURVIVED BY OTHER RELATIVES:
    Please indicate relationship of the surviving relative with the deceased so we could inform you of the documents needed.

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