SINCE 1931
VISAYAN
SURETY & INSURANCE CORP.

Address: Unit 1403, 14/F Keppel Center, Samar Loop cor. Cardinal Rosales Avenue, Cebu Business Park, Cebu City
Tel. No.: (032) 231-1627 ; (032) 415-8287

Email: infovsic@visayansurety.com

PERSONAL ACCIDENT INSURANCE
CLAIM REPORT FORM

To be accomplished by principal insured or beneficiary

Principal Insured _____ Policy No. _____
Claimant's Name _____ Relationship _____
Address _____ Contact No _____
Birthdate of Claimant _____ Occupation _____

1. Date of Accident _____
2. What was the nature of injury? _____
3. Where and how did the accident occur? Describe _____
   _____
   _____
   _____
4. Confined to ☐ House From _____ To _____
   ☐ Hospital From_____ To _____
5. Names & address of all physicians consulted for injury
   Name _____ Address _____
   Name _____ Address _____
   Name _____ Address _____
6. If hospitalized, state name and address of hospital
   Hospital _____
   Address _____
7. Do you have accident insurance with other company?
   ☐ Yes Name _____
   Address _____
   ☐ No

Date _____ Insured / Claimant _____
Signature over printed name

AUTHORIZATION

I hereby authorize any hospital physician or other person who attended or examined me to furnish to the Company or its Authorized Representative any and all information with respect to any injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

Place _____ Insured / Claimant _____
Signature over printed name

Date _____

Please see checklist and instruction in the next page

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ATTENDING PHYSICIAN'S STATEMENT

1. Patient's Name _____
2. Date of Birth _____
3. Diagnosis and concurrent conditions _____
   _____
   _____
4. Name of hospital where confined _____
5. Date symptom first appeared or accident happened _____
6. Date patient first consulted you for this condition _____
7. Nature of surgical procedure if any (describe fully) _____
   _____
   _____
   _____
8. Is patient still under your care for this condition? ☐ Yes ☐ No
   If no, give date of last treatment. Date _____
9. How long was or will patient be completely unable to resume normal activities?
   From _____ To _____

Date _____ Physician's Name _____ Signature _____

License No. _____ Address _____ Tel No. _____

CHECKLIST

A. ACCIDENTAL DEATH CLAIM

1. Attending Physicians Statement
2. Police Investigation Report or Statement of Witness/es
3. Birth Certificate of Insured
4. Death Certificate
5. Autopsy Report /Post Mortem Examination
6. Marriage Contract (if married)
7. Burial and Funeral Services Expenses
8. Certificate of Employment (for Group Personal Accident)
9. Certificate of Bonafide Student (for Student Personal Accident)

B. MEDICAL REIMBURSEMENT

1. Attending Physicians Statement
2. Police Investigation Report or Statement of Witness/es
3. ORIGINAL Medical Bills and Official Receipts with Doctor's prescription attached

INSTRUCTIONS TO CLAIMANTS

1. Accomplish Accident Claim Report Form
2. Accomplish Attending Physician's Statement Form
3. Attach necessary documents (refer to checklist)
4. Send filled out Accident Claim Form, Physician's Statement Form and necessary documents to infovsic@visayansurety.com or upload them on the website under the PA Claims tab