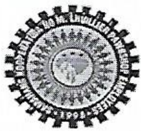

SAMAHANG KOOPERATIBA NG MLHUILLIER PAWNSHOP EMPLOYEES
11th FLOOR HEART TOWER CONDOMINIUM 108 VALERO ST. SALCEDO VILLAGE, MAKATI CITY
TELEFAX : (02) 843-2485 CELLPHONE: 0947-999-1747 Email: sakoheart@rocketmail.com

HOSPITALIZATION CLAIM FORM

PART I: TO BE COMPLETED BY THE INSURED INDIVIDUAL (EMPLOYEE OR MEMBER)

NAME OF CLAIMANT ______________________ CIVIL STATUS __________

PRESENT ADDRESS ______________________ POSITION __________

If Claim is for Dependent Patient's Name Date of Birth __________
Relationship __________

Resides with Insured Individual [ ] YES [ ] NO Married [ ] YES [ ] NO Sex [ ] Male [ ] Female

Is Dependent Employed? [ ] YES [ ] NO By whom? Position __________

When symptom was noticed? Have you consulted a doctor? What were the findings/diagnosis?

Name of Physician/s you/patient have you consulted prior to this confinement

Address of the Physician/s you/patient have consulted?

TO BE ANSWERED ONLY IF INJURY IS DUE TO ACCIDENT

When and where did this accident happe Please indicate time

What was the insured person doing when it happer State how it happened.

Was the injured person at work when it happened? If so,for whom?

Is this patient covered by any other group insurance plan? [ ] YES [ ] NO
If yes,state with what insurance company.

Was the injured person hospitalized? [ ] YES [ ] NO

Name of Hospital: __________ Name of Attending Physician: __________

I hereby certify that the foregoing statements,including any accompanying statements are to the best of my konwledge And belief,true,correct and complete.I hereby authorize any physician to furnish and disclose all kown acts concerning this Disability Samahang Kooperatiba ng Mlhuillier or to its authorized representative.

In the event of underpayment or overpayment of claim due to changes in benefits or wrong computation of claim, I and Samahang Kooperatiba ng Mlhuillier.Mutually agree to pay or to reimburse the affected party corresponding to the amount involed.

DATE CLAIMANT'S PRINTED NAME & SIGNATURE

PART II - TO BE COMPLETED BY THE EMPLOYER

NAME OF EMPLOYER : SAMAHANG KOOPERATIBA NG MLHUILLIER PAWNSHOP'S EMPLOYEES (SAKO)

Claim is made for : ____ Employee (Name Above) ____ Spouse of Employee ____ Son/Daughter of Employee

If Employee is the disabled person,please answer below:
a. When did he stop to work? __________ Time : __________
b. When did he return to work? __________ Time : __________
c. If not back at work,when do you expect him to return? __________

Did disability occur due to [ ] YES [ ] NO Has claim been filled [ ] YES [ ] NO
Occupational cause / causes [ ] YES [ ] NO under Employees Compensation Commission

PLEASE ISSUE REIMBURSEMENT CHECK IN FAVOR OF:

_____ Employee / Claimant _____ Employer _____ Broker

I HEREBY CERTIFY that the foregoing statements are true correct and complete to the best of my knowledge and belief. 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 Samahang Kooperatiba ng Mlhuillier Pawnshops Employees Cooperative (SAKO) In the event of underpayment or overpayment of the claim due to changes in the benefits or wrong computation of claim, our Samahang Kooperatiba ng Mlhuillier Pawnshop mutually agree to pay or reimburse the affected party to the amount involved.

PRINTED NAME SIGNATURE POSITION / TITLE DATE