East West Ageas Life Insurance Corporation
15th Floor, One World Place, 32nd Street, Bonifacio Global City, 1634 Taguig City, Philippines
Tel: +63 2 8683 8766 TIN: 009 156 012 000

Hospital Cash Claim Form

Hospital confinement can be inconvenient – you lose time with your family and at work. We know how important this claim is to you, so we're here to help you through this.

Please fill out this form, along with the other required documents, and send it via email to AskMe@troo.life.

Once submitted, we'll update you on the status of your claim through your mobile number and/or email address.

This form should be filled out by the Insured but should also be signed by the Policy Owner if the Insured is different from the Policy Owner. The claim benefit, however, will be payable to the Policy Owner.

Please do not affix your signature on a blank form. No fees, commission, or charges of whatever nature are payable to employees of Troo in respect of this claim.

If you have further questions or concerns, please feel free to reach us directly via any of the following:

Email: AskMe@troo.life
Mobile: 0917.6314305 or 0917.5451683
Landline (Duo): (02) 7215.0275 or (02) 7616.6747

Warning: Filing of fraudulent claim is penalized by law
Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed 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.

Mandatory Requirements

- [ ] Hospital Cash Claim Form
  This form must be clearly and completely filled out by the Insured, who was confined. The Policy Owner must also sign this form if the Policy Owner is different from the Insured. The claim benefit, however, will be payable to the Policy Owner.

- [ ] Attending Physician's Statement
  This must be duly accomplished by the physician/s who attended to the Insured.

- [ ] Statement of Account from the hospital

- [ ] Clinical Abstract

- [ ] One (1) valid identification card (with picture and signature) of the claimant

Other Requirements:

- [ ] Police Report or Incident Report – if confinement is caused by an accident

- [ ] Complete medical records may be required

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IMPORTANT: Every question must be completely and distinctly answered to facilitate the claims processing. Troo reserves the right to require further information should it be deemed necessary.

To be accomplished by the Insured

Policy Number/s

Full name of Insured

Last name | First name | Middle name

Date of birth (M M D D Y Y Y Y) | Contact number | Email address

Complete address

Occupation

Nature of Claim (please check)

☐ Illness ☐ Injury ☐ Others (please state)_____

Please describe nature of claim.

When did the symptoms first appear or when did the injury happen?

When did you first consult a medical doctor for this condition?

Payment Instructions: Please choose your preference.

☐ E-Settle to your bank account

Name of bank and branch

Account name

Account number

Note: Your bank might have inward charges, please check with them. For Philippine Peso payouts, please elect a Philippine Peso account. For dollar payouts, kindly elect a dollar account.

☐ Pick up check

EastWest Store

Note: We only allow checks for Policy Owners with no bank account.

Declaration and Authorization

1. I hereby certify that the foregoing answers are true and correct to the best of my knowledge, and hereby authorize all doctors and/or other persons who attended to/treated me and all hospitals and/or other institutions to furnish full information and complete copies of all medical records regarding this claim.
2. I also certify that all information including all of my personally identifiable and sensitive information, which I have voluntarily provided to Troo, through this Form and related documents is true and correct to the best of my own knowledge and belief;
3. I further agree and authorize Troo to collect, process, store, modify and destroy any submitted personal, sensitive personal and privileged information, as well as disclose, share or transfer this information to its subsidiaries, affiliates, agents, representatives, industry associations, outsourced service providers, and to local and foreign regulatory authorities, for legitimate purposes, including but not limited to:

    a. Process the Claim, and provide all services related thereto;

    b. Process all personal, sensitive personal and privileged information in accordance with the Data Privacy Act of 2012, its implementing rules and regulations, and any other related issuances of the National Privacy Commission;

    c. Upload all medical information to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud, with due regard to your right to privacy, in accordance with Insurance Commission Circular Letter No. 2016-54 (accessible at www.insurance.gov.ph);

    d. Promote/conduct cross-selling, marketing and direct marketing activities, provide advice or information covering products or services I may be interested in, or communicate with me through mail/email/fax/SMS/ telephone for any purpose;

    e. Comply with applicable laws or regulations (e.g. Anti-Money Laundering laws, U.S. Foreign Account Tax Compliance Act, Data Privacy Act)

_____ _____

Insured's Signature Date and Place of Signing

_____

Policy Owner's Signature, if different from Insured

To be accomplished by the Attending Physician:

Full name of patient

Last name | First name | Middle name

Type of availment

○ Elective ○ Emergency

Age

Date of availment or admission | Date of discharge

Brief clinical history and pertinent physical findings

When did the symptoms first appear or when did the injury happen?

When were you first consulted about the patient's condition?

Had the patient suffered from the same or similar condition? If yes, please provide details.

Final diagnosis

Please provide details of any surgical operations performed or contemplated to be performed on the patient.

Date of operation	Name of physician and hospital	Type of operation

Names and addresses of other physicians that treated the patient for this illness/injury

Name of physician/hospital/ institution	Address	Contact numbers	Dates attended

I hereby certify that the answers and information given above are full, complete and true.

I further authorize the Medical Director or any of his/her authorized representatives to furnish Troo or its authorized representatives all medical records of the patient.

A photographic copy of this authorization is valid as the original.

Complete Name and Signature of Attending Physician	
Date Signed	
Specialization	
License no	
Contact numbers	
Email address	
Clinic address	
Clinic hours	