

Management System ISO 9001:2015

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Service. Excellence. Innovation.

MEMORANDUM - 4750 - 2022 - 300

TO

.

**ALL DOST-SEI On-going Graduate Scholars** 

FROM

OSETTET BIVO PAD

:

Director, SEI

**SUBJECT** 

**DOST-SEI Graduate Scholars Group Personal Insurance Coverage** 

DATE

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11 October 2022

In connection with the Group Personal Accident Insurance of DOST-SEI On-going Graduate scholars, we are pleased to inform you that for AY 2022-2023, the scholars have been enrolled with the Fortune General Insurance Corporation from September 25, 2022 to September 25, 2023 with the following insurance benefits:

A. Personal Accident Benefits:	Graduate
1. Accident Death and Disablement	1,000,000.00
2. Unprovoked Murder and Assault	1,000,000.00
3. Public Conveyance	1,000,000.00
4. Accidental Medical Reimbursement	100,000.00
5. Bereavement Assistance (Accident Related Causes)	100,000.00
6. Daily In-Hospital Cash Assistance commencing on the 1st day up to maximum of 45 Days Due to Accident	500.00 per day
7. Fire Assistance	5,000.00
8. Ambulance Assistance	3,000.00
B. Health Benefits (Only for Inpatients, and coverage includes  Dengue and COVID-19)	
Daily Room & Board Cash assistance commencing     on the 1st Day up to Maximum of 10 days	500.00 per day
2. Hospital Emergency Services	Maximum of 3,000.00
2a. Laboratory, x-ray and diagnostics procedures and interpretation	
2b. Drugs prescribe by a physician and administered in the hospital	
Facilities required for diagnosis and treatment including necessary equipment and supplies	
3. Doctor's fee during confinement	Maximum of 1,000.00
4. Medicine Expense during confinement	Maximum of 1,000.00
*Note: Pre-existing and congenital conditions are not covered.	

Claimant must accomplish a Claim Report Form and submit to SEI together with the supporting documents as indicated in the Claim Requirements and endorsement from Project Leaders/Director, if applicable. Claims must be submitted within thirty (30) days from the date of accident or confinement. Otherwise, claimant must submit a letter stating the reason for the late submission of request.

Thank you.

Encl.: a/s

### FORTUNE GENERAL INSURANCE CORPORATION



4/F Citystate Centre, 709 Shaw Blvd., Pasig City Philippines Trunk Line: (632) 8706-3959 www.fgeninsurance.com

### **CLAIMS REPORT ACCIDENT & HEALTH INSURANCE**

## NOTICE TO INSURED / CLAIMANTS

- Accomplish Part A of this form by answering all question accurately and completely, placing "N.A." where not applicable and by checking the appropriate boxes.
- Request your attending physician to accomplish Part B of this form, "Attending Physician's Statements".
- Attach original or copy of documents cited hereunder. You will be notified in case additional documents are needed.
- Forward this form with the pertinent documents to any office of Fortune General Insurance Corporation near your vicinity. 4

#### REQUIREMENTS ACCIDENTAL MEDICAL REIMBURSEMENT D. SURGICAL BENEFIT A. Police Report / Affidavit of the Claimant 1. Hospital Bill 2. Medical Certificate, Bills & Receipts Physician's Prescription (RX)

- Certificate of Insurance / Endorsement DISMEMBERMENT / DISABLEMENT
- Police Report \*

3.

- Notarized Affidavit of the Claimant \*\* 2.
- 3 Operating Room Record
- **Detailed Clinical Summary** 4.
- HOSPITAL INCOME BENEFIT
  - Police Report \*
  - Notarized Affidavit of the Claimant \*\* 2.
  - 3. Hospital Bill
  - Hospital Discharge Summary / Admitting History 4
  - Certificate of Insurance / Endorsement

- **Detailed Clinical Summary**
- Operating Room Record 3
- Certificate of Insurance / Endorsement
- DEATH F
  - 1. Death Certificate
  - Police Report \* 2.
  - Notarized Affidavit of the Claimant \*\* 3
  - Proof of Relationship to Beneficiary
  - Certificate of Insurance / Endorsement
- If claim is accident related
- If due to illness

Note: In case of death while riding as a passenger, the Police Report must indicate that the person is a passenger of a Passenger Utility Vehicle (PUV).

Other Documents as may be needed, such as:

- 1. Affidavit of Two Dis-Interested Person
- 2. Certification
- 3. Waiver of Rights

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	BI THE MOUNTED / CLAIMANT	
Name of Group, If group policy	Policy No.	
Full Name of the Insured	Full Name of Claimant ( other than insured )	
Address	Birthdate of Claimant	
Relationship of Claimant to insured	Occupation	
a. Date injured or date of illness: Month		
b. If injured, described in detail where and how the accident happened		
c. If due to illness, describe nature		
If due to illness, have you received medical treatment		
Or advice before this condition? If Yes, Please give detail Yes	□ No	
	an : Date :	
Indicate name and address of attending physician or surgeon :		
Name : Ad	ldress:	
	N .	
If hospitalized		
Hospital Name : Ad-	dress:	
	-	
Period of hospital confinement :		
From : To	: ,	

Privacy Consent Statement, I declare that all the information that I provide in this form are mine, true, correct, and updated. By submitting this Incident Report, I authorize and provide my explicit consent to FGEN's Data Processing, Profiling and Sharing provisions as required under Republic Act 10173 and other applicable laws and regulations. I also agree to FGEN's Privacy Policy.

### AUTHORIZATION

Signature of Insured / Claimant :	Date Signed ;			
	Tel. / Mobile No.			
PART B – ATTENDING PHYSICIAN'S STATEMENT				
Patient's Name :	Age :	Say:		
Nature of illness or injury :				
a. Chief Complain				
b. Final Diagnosis				
c. Brief history of present illness				
d. Complication, if any				
e. If fracture or dislocation occurred, state whether complete or incom	plete			
f. If loss of sight, check whether Right Eye	Left Eye	☐ Both Eye ☐ Partial and Recoverable		
When did the symptoms first appear or the incident happen?		- raitial and Recoverable		
s the condition due to pregnancy?	0	No		
When did the patient first consult you for this condition?				
lature of surgical or obstetrical procedure, if any (describe fully)				
ame of Hospital:		e Discharged:		
		* H		
ow long the patient was or will be continuously / totally disabled (unal				
the condition due to injury or sickness arising out of patients employn	nent?			
tending Physician :				
gnature:				
ense No. :				
R No. :				

# 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 the 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."