Prudential Guarantee
PGA Insurance

NOTIFICATION OF CLAIM
(Hospital Income Benefit)

Required claim documents must be attached and all sections must be completed or claims will not be processed.

A. PARTICULARS OF CLAIMANT

Principal Insured _____

Policy No. _____

Claimant's Name (if other than insured) _____

Relation to Principal Insured _____

Address _____

Tel./CP No._____

Birth Date of Claimant_____ **Occupation** _____

B. AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the hospital, physician, or other person who has attended or examined me to furnish Prudential Guarantee and Assurance, Inc. or its authorized representative any or all information with respect to my hospitalization, including but not limited to hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Claimant over printed name **Date**

C. STATEMENT OF CLAIMANT

Confinement Detail:

1. **Hospital / Medical Institution** _____
2. **Address** _____

   _____
3. **Date & Time of Admission** _____ _____
4. **Date & Time Discharged** _____
5. **Attending Physician** _____
6. **Nature of Hospital Confinement** _____

TO BE COMPLETED BY THE ATTENDING PHYSICIAN/SURGEON ONLY

ATTENDING PHYSICIAN'S REPORT

1.(a)Diagnosis of Condition(s)

_____

_____

_____

_____

_____

(b) State diagnosis of condition in respect of which hospitalization was required

_____

_____

_____

_____

(c) Are any of the condition related due to:

i Is sickness existed prior to **DOE** If "yes" please explain

_____

_____

_____

ii Pregnancy? ( ) YES ( ) No

2. Were private nurse services necessary? If "yes" state how many days

_____

_

3. Medical History ? discharge summary report

_____

_____

__

_____

_____

_____

___

_____ _ _____

Signature of over printed name of Attending Physician Address

PTR No. _____

-EP

DATE REPORTED