PIONEER®
YOUR INSURANCE

PET OWNER'S PERSONAL ACCIDENT INSURANCE

Pet Dog and Cat Insurance Claim Form

The Company makes no admission of liability or waiver of rights by furnishing this form.

IMPORTANT INSTRUCTIONS:

1. For claims processing, Insurer should be notified within 30 days from the discovery of the incident.
2. Failure to complete this claim form could result in a delay in processing your claim.
3. Submission of required documents does not guarantee approval of your claim. The submitted documents will be reviewed and evaluated, subject to limits, terms and conditions of your existing policy.
4. Please refer to your Pet Dog and Cat Insurance claims checklist for the complete list of claim requirements.

SECTION I: TO BE COMPLETED BY THE PET OWNER

Full Name of Insured Pet Owner: [Given Name] [Middle Name] [Last Name] [Suffix]

Date of Birth: [MM/DD/YYYY]	Sex:
Mobile No.:	Email Address:

Present Residence: [Street] [Barangay] [City] [Province] [Zip Code]

Civil Status:	Occupation:
Policy Number:	Mobile No.:

PET DETAILS

Name:

Species:	Breed:	Gender/Sex:
Date of Birth:	Neuter Status: ☐ Neutered ☐ Intact	

If exact Date of Birth is unavailable, please indicate at least the estimate the date, to the month (if possible) and year age of the Pet.

Color:	Distinguishing Mark:

1) Is your pet currently covered by another insurance policy? ☐ Yes ☐ No. If "Yes", please provide the following information:

Name of Insurance Company:
Policy Number:

2) Which Pet Owner's Personal Accident benefit are you claiming for?

- ☐ Insured Pet Owner's Accidental Death and Disablement Benefit
- ☐ Pet Medical Reimbursement for Covered Accidental Injuries Benefit
- ☐ Pet Medical Reimbursement for Covered Illnesses Benefit
- ☐ Pet Owner's Liability
- ☐ Pet Acute Dental Conditions Benefit
- ☐ Pet Accidental Death or Essential Euthanasia Benefit
- ☐ Petnap Benefit
- ☐ Pet International Travel Emergency Medical Treatment Benefit

NOTE: For the complete list of benefits, please refer to your Schedule of Benefits and Policy Contract.

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1. Describe fully how your injury occurred (include date, time & exact place).

2. Give the name (s), address(es) and contact details of your usual attending physician(s).

PET MEDICAL REIMBURSEMENT FOR COVERED ACCIDENTAL INJURIES BENEFIT/PET MEDICAL REIMBURSEMENT FOR COVERED ILLNESSES BENEFIT/PET INTERNATIONAL TRAVEL EMERGENCY MEDICAL TREATMENT BENEFIT/PET ACUTE DENTAL CONDITIONS BENEFIT

1. State the nature of your Insured Pet's illness or injury.

2. Has the insured pet suffered a similar condition or a recurrence of a previous illness or injury? ☐ Yes ☐ No

If YES, please provide details, including date of immediate past occurrence.

3. State the net amount being claimed.

4. Give the name (s), address(es) and contact details of the Insured Pet's veterinarian.

PETNAP BENEFIT

1. Describe fully the circumstances around the time when how the Petnap occurred (include date, time & exact place).

PET OWNER'S LIABILITY

1. Please state the circumstances which gave rise to the liability.

State the net amount being claimed.

PET ACCIDENTAL DEATH OR ESSENTIAL EUTHANASIA BENEFIT

1. Place of Death
2. Date of Death
3. Cause of Death
4. Give the name (s), address(es) and contact details of the Insured Pet's veterinarian

CLAIM PAYMENT DETAILS

☐ DIRECT CREDIT TO MY NOMINATED BANK ACCOUNT

Name of Bank	:
Bank Branch	:
Bank Address	:
Account Name	:
Account Number	:

Once claim is approved, we will require submission of a copy of proof of bank account ownership (ie. Full Picture showing the front inside cover of bank passbook, ATM Card with Account Number and account name duly indicated, Deposit Slip issued by the bank as proof of cash/check deposit, Bank Certificate / Statement (issued 2019 onwards).

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☐ **CHECK**

Name as it should appear on check:

NOTES APPLICABLE TO ALL PAYMENT OPTIONS:
1. Whenever applicable, the cost of direct crediting will be deducted from the approved claim amount.
2. In all payments, payee should be of legal age (18 years old and above).
3. Claims Payment Details are still subject to Pioneer's validation.
4. Check becomes the default option if preferred mode of payment is left blank

DECLARATION

NOTE: 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 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.

I/We hereby certify that this claim form does not contain any false, misleading or incomplete information. I/We understand and accept that, in the event that this claim is found to be fraudulent, in whole or in part, the Policy shall be void and all the rights to recover thereunder in respect of past or future claims shall be forfeited.

I/We hereby authorize PIONEER INSURANCE & SURETY CORPORATION, its reinsurers and/or its duly authorized representatives to collect, controller and processor who collects, holds, processes or uses any of my and the named insured's personal information, and for any of the latter to furnish PIONEER INSURANCE & SURETY CORPORATION, its reinsurers and/or its duly authorized representatives with any personal information, sensitive personal information and privileged information, including copies (original or certified) of documents, relating to any of my and the names insured's personal information. THIS AUTHORIZATION is being made in connection with any claim on the insurance policy or policies issued by the insurance company on the life and/or health of the abovementioned insured. It is understood that any action of any medical practitioner, medically related facility, insurance company, government agency or instrumentality or any other personal information controller and processor who collects, holds, processes or uses any of my personal information may take in connection with this authorization releases said persons or entities or any and all members of their staff from any responsibility or obligation in connection with the release or processing of such records or information.

I/We hereby certify that I/we have carefully read and clearly understood the terms of the above said authorization, and do hereby voluntarily accept and acknowledge the same as an informed expression of my free will.

Any payment made by PIONEER INSURANCE & SURETY CORPORATION, or any payment received by me shall constitute as full, final and complete settlement of this claim. I further agree that the company is subrogated to my or my principal's rights of recovery on all claims and rights of action to the extent of the payments made and/or on account of the losses incurred or which may be incurred by the Company against any person, corporation or entity in connection with this claim and I further agree to authorize the Company to commence all legal actions and proceedings necessary to enforce my claim or recovery thereof with any undertaking to extend my cooperation or assistance whenever necessary.

I agree that a photocopy or facsimile of this release shall be as effective as the original.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

Address: _____ Tel. No. _____

_____ _____

Signature over Printed Name Date

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SECTION II: TO BE COMPLETED BY THE VETERINARY SURGEON	
Please ensure that you include a full clinical history of the pet in addition to an itemized invoice showing the date and cost for all treatments provided. If prescriptions are included, please ensure these show the type and quantity of drugs provided. It is the Insured Pet Owner's responsibility to complete and sign Section I of this claim form. Please ensure that this has been done before the form is brought to you.	
Diagnosis:	
Technique or surgical procedure conducted:	
Treatment Dates: From (MM/DD/YYYY)	to (MM/DD/YYYY)
Date of first clinical signs (include dates of previous related or similar conditions)	
How long has this pet been a patient of your clinic?	
IN THE EVENT OF PET'S DEATH	
Date of Death (MM/DD/YYYY):	Cause of Death:
If Euthanasia was performed, please indicate why it was medically necessary:	
VETERINARY DECLARATION I hereby certify that the above statements and facts which answer the preceding questions are true and that I have not withheld any material information in connection with the above condition. I certify that, to the best of my knowledge, all the information contained in this form is correct and accurate.	
Veterinary Surgeon's Signature over Printed Name:	License No.:
	Contact No.:
Date:	E-mail Address: