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

Critical Illness/Disability Claim Form

We know that this claim is important to you, so we're here to help you through this.

Please fill out this form and send it to us via email, along with the other required documents, 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 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.

Mandatory Requirements

- [ ] Critical Illness/Disability Claim Form

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

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

- [ ] Certified true copies of complete confinement records and medical results

Additional mandatory requirements for Critical Illness:

- [ ] For Critical Illness – Heart Attack
  a. ECG Tracings and Official Results
  b. Copy of all Laboratory Blood Results
  c. Complete hospital confinement records, including the history of the medical condition/illness
- [ ] For Critical Illness – Cancer
  a. Histological-Pathological Report
  b. Complete hospital confinement records, including the history of the medical condition/illness
- [ ] For Critical Illness – Stroke
  a. CT Scan or MRI Report
  b. Attending neurologist report and most recent neurological exam (within 30 days)
- [ ] For Other Critical Illnesses
  Complete hospital confinement records, including the history of the medical condition/illness
  For additional requirements, please contact AskMe@troo.life.

Additional mandatory requirements for Disability:

- [ ] Medical Records
  a. Clinical Abstract
  b. Laboratory Results
  c. Operative Results, if any
  d. Complete hospital confinement records, including the history of the medical condition/illness
- [ ] Certificate of Employment (for group insurance claims)
- [ ] Photo of the dismembered body part (if due to loss of body part)

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

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Critical Illness/Disability Claim Form

IMPORTANT: Every question must be completely 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/Patient

Policy Number/s

First name

Middle name

Last name

Contact Number

Email address

Complete Address

Nature of Claim (please check)

☐ Critical Illness ☐ Disability

Occupation

When did you first experience signs or symptoms of the medical condition?

M	M	D	D	Y	Y	Y	Y

When did you first seek consult or treatment for the medical condition?

M	M	D	D	Y	Y	Y	Y

Provide the name of the doctor you first consulted and the complete clinic or hospital address.

Did you experience the same or similar conditions in the past?
If yes, please provide details (name of the medical condition, when it started, medication, etc.).

Additional questions for Disability:

When was the last date that you reported to work?

M	M	D	D	Y	Y	Y	Y

When did you return to work? If not, when are you expected to return to work?

M	M	D	D	Y	Y	Y	Y

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Payment Instructions: please choose your preference.

☐ E-Settle to your bank account

Name of bank and branch

Account number

Account name

Note: Your bank might have inward charges, please check with them. For peso payouts, please elect a 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 all information including all personally identifiable and sensitive information that I have voluntarily provided to Troo, through this Form and related documents, is true and correct to the best of my knowledge and belief.
2. I 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.
3. I further agree and authorize Troo to collect, store, modify and otherwise process 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 this 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 the Insured

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To be accomplished by the Attending Physician

IMPORTANT: All answers must be entirely in the Physician's handwriting.
Any expense/s incurred on the issuance of this statement shall be borne by the insured/patient.

Full Name of Insured/Patient:

Last name

First name

Middle name

When did the insured/patient first consult with you and what were your findings?

How long has the insured/patient been experiencing such illness or disabilty from the date of insured/patient's first consultation? **State duration in months.**

M M

Please indicate approximate date when the insured/patient first noticed symptoms of illness or disability?

M M D D Y Y Y Y

How long do you believe the symptoms had been present before you were first consulted for the illness or disability? **State duration in months.**

M M

Please describe fully the illness or disability of insured/patient and its severity:

Objective findings supporting the diagnosis and prognosis. Please include the dates of tests and examinations performed, and the results of histopaths, current CT-Scans, ECGs, MRIs, X-rays, and other laboratory and special tests conducted.

What other medical condition/history contributed to the current illness or disability?

Was the insured/patient treated previously for this illness or disability? If yes, please provide details.

Duration of illness or disability.

From M M D D Y Y Y Y to M M D D Y Y Y Y

Please provide details of any surgical operations or treatment modalities (i.e., chemotherapy, physical therapy) performed or contemplated for the insured/patient:

Date of Operation / Treatment	Name of Physician and Hospital	Type of Operation / Treatment

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Please provide details of other physicians who have attended to or consulted by the insured/patient.

Name of Physician / Hospital / Institution	Address	Contact Numbers	Dates Attended

Additional questions for Disability:

Was the disability caused by an illness or accident? If yes, please specify and provide details.

How would you classify the disability? (Total Permanent/Total Temporary/Partial Permanent/Partial Temporary)

Given the insured/patient's current illness or disability, will the insured/patient still be able to do any kind of work/occupation?

Given the extent of the disability, which of the following activities of daily living is the insured/patient unable to perform?
Please check all that apply.

- ☐ Continence/ Toileting — Since when? M M D D Y Y Y Y
- ☐ Dressing — Since when? M M D D Y Y Y Y
- ☐ Washing and Bathing — Since when? M M D D Y Y Y Y
- ☐ Feeding — Since when? M M D D Y Y Y Y
- ☐ Mobility, getting in and out of bed, moving to another place, or walking without using a wheelchair — Since when? M M D D Y Y Y Y

If the illness or disability was caused under the influence of liquor or use of prohibited drugs, please specify and provide details.

I hereby certify that the answers and information given above are full, complete, and true based on medical records.
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 insured/patient.
A photographic copy of this authorization is valid as the original.

Complete Name and Signature of Attending Physician	
Date Signed	
PTR Number	
Specialization	
License no	
Contact numbers	
Email address	
Clinic/Hospital Affiliation	
Clinic/Hospital Address	
Clinic hours	

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