ARMED FORCES AND POLICE MUTUAL BENEFIT ASSOCIATION, INC.
Col Bonny Serrano Road cor E. Delos Santos Avenue, Camp Aguinaldo, Quezon City
Contact Nos. (02) 8822-MBAI (6224) Website: www.afpmbai.com.ph
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REQUEST FOR MEDICAL EVALUATION FOR DISABILITY BENEFIT CLAIM

Branch / Extension Office _____ Control No. _____

FOR MEDICAL DIRECTOR

LAST NAME:		DATE OF BIRTH (DD/MM/YYYY)	
FIRST NAME:	EXTN NAME:	AGE:	CIVIL STATUS:
MIDDLE NAME:		BRANCH OF SERVICE:	
RANK:	SERIAL/BADGE/ACCT NO.:		GENDER:
UNIT ASSIGNMENT:	UNIT ADDRESS:		
LANDLINE NO.:	CELL PHONE NO.:	PHYLSIS NO. (PSN):	
PRESENT ADDRESS:			
PERMANENT ADDRESS:			
DATE OF INJURY:	CAUSE OF INJURY:		
PLACE OF INJURY:			
EFFECTIVITY OF INSURANCE:	AMOUNT:		

RESULT OF MEDICAL EVALUATION

EVALUATED BY: _____ DATE: _____
MEDICAL DIRECTOR

PREPARED BY: _____
SUPERVISOR DEATH & DISABILITY BENEFITS SECTION

PRIVACY NOTICE - as per REPUBLIC ACT NO. 10173

AFPMBAI upholds an individual's data privacy rights and observes that all personal information, sensitive personal information and privileged information collected and to be collected are processed or recorded, managed, organized, stored, updated, retrieved, consolidated, used, blocked, and erased according to the Data Privacy Act of 2012 (RA 10173), its Implementing Rules and Regulations (IRR), and various Circulars under the principles of transparency, legitimate purpose, and proportionality.

I hereby give my consent to the processing, sharing, and/or transferring of my personal data relating to my account/s, without notice, to AFPMBAI, its service providers and entities or third parties having authority or right to such disclosure of information as in the case of regulatory agencies, governmental or otherwise, which have required such disclosure from AFPMBAI, also to enable AFPMBAI to service my account/s, to provide all existing features and future enhancements thereto, and to avail other AFPMBAI products, services, facilities and channels as the AFPMBAI deems necessary. I agree to hold AFPMBAI, its affiliates, subsidiaries and third party service providers free and harmless from any liability arising from or in connection with the consent herein given.

_____
Signature over Printed Name

REQUIREMENTS FOR DISABILITY/BIA

1. Medical Certificate from Doctor or Hospital
2. Picture (whole body with affected area of disability)
3. AFP, PNP, BJMP & PCG ID (photo copy Back-to-back)
4. Statement of Service / Service Record
5. Latest Payslip
6. Journal Report (AFP & PCG) or
   Incident Report (PNP, BFP & BJMP)
7. Narrative Summary Report from Hospital
8. For BIA: Medical Certificate with Physical Profile

Release of Claim

☐ For Pick Up ○ Head Office ○ AFPMBAI BRANCH _____
☐ For Deposit ○ ATM/Acct No.: _____
○ Bank/Branch _____
☐ For Mailing ○ Present Address ○ Permanent Address ○ Unit Add
☐ Ecard/MBAI ID Card ○ Ecard No. _____

NOTE: All documents should be authenticated by the accredited claims benefits officers of repective branches of service.

As of June 2020