ARMED FORCES AND POLICE MUTUAL BENEFIT ASSOCIATION, INC.

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DHIB Form v202503

DAILY HOSPITAL INCOME BENEFIT CLAIM FORM

Branch / Extension Office

Date of Filing

MEMBER'S INFORMATION

LAST NAME	FIRST NAME	EXTN NAME (JR., SR.)	MIDDLE NAME

BOS	SERIAL / BADGE NO. / OTHER GOVT ISSUED ID (PLEASE SPECIFY ID AND ID NO.)	TIN	BIRTH DATE MM DD YYYY	RETIREMENT DATE MM DD YYYY

RANK	MOBILE NUMBER	ALTERNATE NUMBER (MESSENGER/VIBER/TELEGRAM)	EMAIL ADDRESS (PLEASE WRITE IN **UPPER** CASE)

COMPLETE UNIT ADDRESS/OFFICE/BUSINESS ADDRESS

ROOM / BUILDING NUMBER | STREET / SUBDIVISION | BARANGAY / SITIO / PUROK / BARRIO

MUNICIPALITY / TOWN / CITY | PROVINCE | ZIP CODE

COMPLETE PRESENT ADDRESS (CURRENTLY RESIDING)

ROOM / BUILDING NUMBER | STREET / SUBDIVISION | BARANGAY / SITIO / PUROK / BARRIO

MUNICIPALITY / TOWN / CITY | PROVINCE | ZIP CODE

COMPLETE PERMANENT ADDRESS

ROOM / BUILDING NUMBER | STREET / SUBDIVISION | BARANGAY / SITIO / PUROK / BARRIO

MUNICIPALITY / TOWN / CITY | PROVINCE | ZIP CODE

CONFINEMENT DETAILS

NAME OF HOSPITAL/CLINIC:

DIAGNOSIS:

PHYSICIAN'S NAME:

DATE OF HOSPITALIZATION

MM DD YYYY

FROM:

TO:

NUMBER OF DAYS:

RECOMMENDATION OF CONFINEMENT DUE TO:

☐ Diagnosis/Medical Symptoms ☐ Injury/Trauma ☐ Chronic Condition Management

☐ Surgical Procedure ☐ Acute Illness/Infection ☐ Others: _____

PAYOUT OF PROCEEDS

☐ For Pick-Up

◯ Head Office

◯ AFPMBAI Branch _____

☐ For Deposit

Bank _____

Bank Account No. _____

☐ For Mailing

◯ Present Address ◯ Unit Address

◯ Permanent Address

FRAUD WARNING

"Section 251 of The Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed or imprisonment of two (2) years, or both, at the discretion of the court for any person who: a) presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance; or b) 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 such claim."

PRIVACY NOTICE AS PER REPUBLIC ACT NO. 10173

AFPMBAI upholds an individual's privacy rights and observes that all personal information, sensitive personal information, and privileged information collected and to be collected per process or recorded, managed, organized, stored, updated, retrieved, consolidated, used, blocked, and erased according to Data Privacy Act od 2012 (RA10173), its Implementing Rules and Regulations (IRR), and various circular 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 the 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 of Applicant

Date of Application

TO BE ACCOMPLISHED INTERNALLY (for AFPMBAI use only)

MEMBERSHIP CERTIFICATE #: _____

MEMBER'S ID NO.: _____

MEMBERSHIP CONTRIBUTION: ☐ Old Basic ☐ MBAI iProtek

☐ MBAI Protek ◯ Plan 499 ◯ Plan 999

FIRST PAYMENT DATE OF BASIC INSURANCE: _____

PROCESSED BY: _____

RECOMMENDATION FROM MEDICAL UNDERWRITER / MEDICAL DOCTOR

◯ For Approval ◯ For Denial

Reason/s (please specify):

Recommended/Evaluated By: _____ DATE: _____

UPMD Medical Underwriter or Medical Doctor