Republic of the Philippines
Department of Finance
INSURANCE COMMISSION
1071 United Nations Avenue
Manila

Head Office:
P.O. Box 3589 Manila
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Website : www.insurance.gov.ph

Circular Letter No.: 23-2011
Date : June 7, 2011

CIRCULAR LETTER

To : **All Accredited Insurance Providers of Compulsory Insurance Coverage for Agency-Hired Migrant Workers**

Subject : **Reportorial Requirements**

Pursuant to Section 1 of Guideline XI of the Insurance Guidelines on Rule XVI of the Omnibus Rules and Regulations Implementing Republic Act 8042, as amended by Republic Act 10022, the attached forms are hereby required to be accomplished and submitted to this Commission every month. Submission shall be on or before the 10th day following the month covered. The first submission shall cover the period January 1 to June 30, 2011 and due on or before July 10, 2011.

A fine of Five Hundred Pesos (P500.00) per day of delay or after due notice and hearing, cancellation of accreditation, or both, shall be imposed.

This circular shall take effect immediately.

EMMANUEL F. DOOC
Insurance Commissioner

INSURANCE COMMISSION
6-7-11
GEN. RECORDS

Form No. OFW-1

PRODUCTION/PREMIUM REPORT
ON COMPULSORY INSURANCE FOR AGENCY-HIRED MIGRANT WORKERS

(in compliance with Guideline XI Section I -Administrative Monitoring and Supervision of the Insurance Guidelines)

_____(Name of Insurance Company)_____

For the month of _____, 20__

NAME OF POLICY HOLDER/ RECRUITMENT AGENCY	NAME OF OFW	PROOF OF COVER/COI NO.	PERIOD COVERED	DATE OF DEPARTURE	COUNTRY OF DESTINATION	PREMIUM PAID	O.R. NO.

_____

Signature over Printed Name
of Responsible Official with the
Rank of at least Vice President

Form No. OFW-2

CLAIMS PAYMENT REPORT
ON COMPULSORY INSURANCE FOR AGENCY-HIRED MIGRANT WORKERS

(in compliance with Guideline XI Section I -Administrative Monitoring and Supervision of the Insurance Guidelines)

_____(Name of Insurance Company)_____

For the month of _____, 20__

NAME OF OFW	NAME OF BENEFICIARY/IES	ASSURED	MASTER POLICY NO.	PROOF OF COVER/COI NO.	Date Claim Filed	NATURE OF CLAIM	AMOUNT OF CLAIM	AMOUNT PAID	Date Claim Paid	Cash/Check Voucher

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Signature over Printed Name
of Responsible Official with the
Rank of at least Vice President

Form No. OFW-3

CLAIMS DENIAL REPORT
ON COMPULSORY INSURANCE FOR AGENCY-HIRED MIGRANT WORKERS

(in compliance with Guideline XI Section I -Administrative Monitoring and Supervision of the Insurance Guidelines)

_____(Name of Insurance Company)_____

For the month of _____, 20__

NAME OF OFW	NAME OF BENEFICIARY/IES	ASSURED	MASTER POLICY NO.	PROOF OF COVER/COI NO.	NATURE OF CLAIM	AMOUNT OF CLAIM	DATE CLAIM FILED	DATE CLAIM DENIED	REASON FOR DENIAL

_____

Signature over Printed Name
of Responsible Official with the
Rank of at least Vice President

Form No. OFW-4

STATISTICAL REPORT
ON COMPULSORY INSURANCE FOR AGENCY-HIRED MIGRANT WORKERS
(in compliance with Guideline XI Section I -Administrative Monitoring and Supervision of the Insurance Guidelines)

_____(Name of Insurance Company)_____

For the month of _____, 20__

Recapitulation I - Premium Written

Type of Insurance	Total No. of COCs	Premium on Direct Business	Assumed Business		Net Premiums
			Authorized	Unauthorized	
A. Life					
A.1. 1 Land Based					
A. 1.2 Personal Accident					
A. 1.3 Medical Reimbursement					
A. 1.4 Others					
Total					
B. Sea Based					
B.1.1 Natural Death					
B.1.2 Personal Accident					
B.1.3 Medical Reimbursement					
B.1.4 Others					
Total					
Grand Total					

Recapitulation I - Claims Paid

Type of Insurance	Total COCs	Direct Business	Assumed Business		Net Claims Paid
			Authorized	Unauthorized	
A. Life					
A.1. 1 Land Based					
A. 1.2 Personal Accident					
A. 1.3 Medical Reimbursement					
A. 1.4 Others					
Total					
B. Sea Based					
B.1.1 Natural Death					
B.1.2 Personal Accident					
B.1.3 Medical Reimbursement					
B.1.4 Others					
Total					
Grand Total					

_____

Signature over Printed Name
of Responsible Official with the
Rank of at least Vice President