DATA PRIVACY COMPLAINT FORM

DECLARATION:

I declare that the information I will give are true and correct.

_____	_____	_____
Signature above Printed Name (Thumbmark if unable to sign)	Date (MMM/DD/YYYY)	Time (0000H)

TO THE DATA SUBJECT/ COMPLAINANT: If you believe that the processing of your personal data by Insular Health Care, Inc. ("InLife Health Care") has caused you damage or has not been processed according to RA 10173 or the Data Privacy Act of 2012, kindly accomplish this form and send it to our Data Protection Officer, **Atty. Gideon V. Peña**, at 2F Insular Health Care Bldg., 167 Dela Rosa St. cor. Legazpi St., Legazpi Village, 1229 Makati City or via email at dataprivacy@insularhealthcare.com.ph

We will do our best to respond promptly and in any event within one month of the following:

- Our receipt of your complaint;
- Our receipt of any further information we may ask you to provide to enable us to address your complaint;
- Our receipt of an advisory opinion from the National Privacy Commission in case there is doubt regarding the propriety of your complaint, whichever happens to be the latest.

To facilitate the process, we would appreciate if you can provide us with proof of your identity or of your address. Please supply us with a photocopy or scanned image (do not send the originals) of one or both of the following:

1. Proof of Identity (e.g. Passport, Driver's License, PRC ID, NBI Clearance, Postal ID. Please refer to BSP Circular No. 608, s. 2008 for a complete list of 'Valid Identification Cards for Financial Transactions')
2. Proof of Address (e.g. utility bill, bank statement [no more than 3 months from date of issue]).

The information you supply on this form will only be used for purposes of addressing your complaint and serving as its evidence. You are not obliged to complete this form or to submit the above stated documents, and you can make a complaint anonymously. However, if you do not provide your contact details, we may not be able to properly investigate your complaint or inform you of our action, if any.

Date today (MMM/DD/YYYY)			
Name (Last Name, First Name, Middle Name)			
Address			
Contact Number		Email Address	

Please check the appropriate box and read the instruction which accompanies it:

☐ YES, I am the Data Subject. I hereby enclose proof of my identity as stated above.

☐ NO, I am not the Data Subject and I am merely acting on his/her behalf. I have enclosed the Data Subject's written authorization (not applicable for legal guardians of minors) and proof of the Data Subject's identity and my own identity as stated above.

Details of the Data Subject (if Requestor is not the Data Subject):

Name (Last Name, First Name, Middle Name)			
Address			
Contact Number		Email Address	

In order to help us identify the systems that may contain information about you, please check the applicable boxes below that describe the relationship of the Data Subject with InLife Health Care:

☐ HMO Member
☐ Medical Partner/ Provider
☐ Job Applicant
☐ Former Employee or Contractor
☐ Employee or Contractor
☐ Employee's Family Member, Dependent, Beneficiary or Designated Emergency Contact
☐ Employee of InLife Health Care's Supplier or Vendor
☐ Others: _____

Please check the applicable ground(s) of your Complaint:

- ☐ My personal data was collected, recorded, organized, stored, updated, modified, used, blocked, erased, destroyed or otherwise processed without my consent.
- ☐ My personal data was unlawfully shared to someone not authorized to receive the same.
- ☐ My consent was obtained through ☐ fraud, ☐ accident ☐ mistake or ☐ coercion.
- ☐ I did not have full and complete understanding of InLife Health Care's Data Privacy Policy.
- ☐ I feel that my personal data has been unlawfully or unfairly processed.
- ☐ My consent was given by someone who had no authority to give the same on my behalf.
- ☐ Others: _____

DETAILS OF YOUR PRIVACY COMPLAINT. In what way did the collection, handling or processing of your personal data by InLife Health Care interfere with your privacy? Were any of the Data Privacy Principles, set out in the Data Privacy Act of 2012, breached? Please provide as much detail about your complaint as possible e.g. relevant dates, file references, people involved. (You may use a separate sheet if necessary)

PREFERRED OUTCOME. Please indicate what your preferred outcome for the complaint would be. (You may use a separate sheet if necessary)

ACKNOWLEDGEMENT: I hereby confirm that I understand the foregoing and that all information I have given are true and correct.

I understand that any attempt to mislead may result in prosecution.

[Maaaring tawagin ang pansin ng tauhan ng InLife Health Care kung hindi nakakaunawa ng Ingles. Huwag pumirma kung mayroong hindi naiintindihan.]

_____	_____	_____
Complainant's Signature above Printed Name (Thumbmark if unable to sign)	Date (MMM/DD/YYYY)	Time (0000H)

IF DATA SUBJECT IS A MINOR OR INCAPABLE TO GIVE CONSENT

_____	_____	_____
Signature above Printed Name (Thumbmark if unable to sign)	Relationship to Data Subject	Date (MMM/DD/YYYY)

Reason why Data Subject cannot accomplish this form: