The Insular Life Assurance Company, Ltd.
Insular Life Corporate Centre, Insular Life Drive
Filinvest Corporate City, Alabang, 1781 Muntinlupa City
E-mail: headofc@insular.com.ph I Website: www.insularlife.com.ph
Tel.: (632) 8-582-1818 I Fax: (632) 8-771-1717 I VAT REG. TIN 000-464-124-000

Claimant's Statement

INSTRUCTIONS: This form should be submitted to the Corporate Accounts Division of The Insular Life Assurance Co., Ltd., 4/F Insular Health Care Building, 167 Dela Rosa corner Legazpi Streets, Legazpi Village, Makati City 1229 or 2/F Insular Life Cebu Business Center, Mindanao Avenue corner Biliran Road, Cebu Business Park, Cebu City.

FRAUD WARNING: It is unlawful for any person to (a) present or cause to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and (b) fraudulently prepare, make or subscribe any writing with intent to present or use the same, or to allow it to be presented in support of any claim. Such acts shall be punishable by a fine not exceeding twice the amount claimed or imprisonment of two (2) years, or both, at the discretion of the court. (Section 251, Insurance Code, as amended.)

To: The Insular Life Assurance Company, Ltd.

I hereby claim for benefit under the policy/ies of this Company, numbered as follows: ____________________

All of the following answers and statements are true, complete & correct according to my personal knowledge & belief.

I understand that the furnishing of this form and other claim forms by the Company does not constitute an admission that there is any insurance in force.

1. (a) Full name of the deceased: (b) Residence of the deceased: (c) Occupation:	5. If deceased was insured with other companies, please state the following: NAME OF COMPANY / POLICY NO. / AMOUNT OF INSURANCE
2. (a) Birthdate: (b) Birthplace:	6. (a) What is your date of birth? If a married minor, please submit marriage certificate:
3. (a) Date of Death:	(b) Please state your relationship to the deceased such as son, daughter, father, mother, etc.
(b) Place of Death:	(c) Are you a designated beneficiary? If answer is NO please state in what capacity you are filing this claim?
(c) Cause of Death: (d) Date and Place of Interment: 4. (a) Date the deceased first complained of last illness. Give indications:	(d) IF YOU ARE FILING THIS CLAIM IN BEHALF OF MINOR BENEFICIARIES, please give their names and dates of birth and your relation to them below: (State such as father, mother, grandfather, stepfather, etc.) NAME OF MINORS / BIRTHDATE / YOUR RELATION
(b) Names and addresses of all physicians who attended the deceased: (c) Names and addresses of all medical institutions or hospitals where deceased was confined:	(e) As father/mother of said minor/s, have you not been disqualified by a court of law from exercising the right to administer the property of such minor/s? ☐ YES ☐ NO Is/Are the same minor/s under your actual custody and support? ☐ YES ☐ NO

(USE REVERSE SIDE FOR ADDITIONAL INFORMATION)

Done at ____________ this ______ day of ____________, 20______

WITNESS | NAME AND SIGNATURE OF CLAIMANT

ADDRESS OF WITNESS | ADDRESS OF CLAIMANT

CONTACT NOS. OF CLAIMANT

SUBSCRIBED AND SWORN to before me this ______ day of __________, 20____, by the above claimant who exhibited to me his/her Residence Certificate No. A ____________, issued at ____________ on ____________.

Doc. No. ______
Page No. ______
Book No. ______
Series of 20 ______

Notary Public
My commission expires on
____

CLAIMANT'S AUTHORIZATION

This authorizes The Insular Life Assurance Co., Ltd. or its authorized representative to secure whatever information or record you may have regarding the disease or injury for which the deceased was treated or examined. This authorization is being made in connection with any claim on the insurance policy issued by said insurance company on the life of the deceased.

This authorization discharges you or any authorized member of your staff from any responsibility or obligation in connection with the release of such record or information.

Signed at ____________ this ______ day of ____________, 20______

WITNESS | BENEFICIARY/CLAIMANT

WITNESS | RELATIONSHIP TO THE DECEASED