InLife INSULAR LIFE

The Insular Life Assurance Company, Ltd.
Insular Life Corporate Centre, Insular Life Drive
Filinvest Corporate City, Alabang, 1781 Muntinlupa City
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Tel.: (632) 8-582-1818 I Fax: (632) 8-771-1717 I VAT REG. TIN 000-464-124-000

Insured's Statement Disability Claim

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.)

I hereby make claim under the policy/ies of this Company, numbered as follows: ______________________

All of the following answers and statements are true and complete, and correctly recorded.

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

1. (a) Name
   (b) Address
   (c) Contact No.
   (d) Date & Place of Birth
   (e) Occupation
2. (a) Nature of Disability
   ☐ Illness ☐ Injury
   (b) Date & Place of Commencement of Disability
   ____
   ____
   (c) If through accident, was it reported to the Police or PC authorities? __________ If so, please attach Police or PC Investigation Report.
3. (a) Give complete history of your illness or how injury was sustained. (Use reverse side if necessary).
   ____
   ____
   ____
   (b) What was your work immediately prior to your becoming disabled?
   (c) When was the last date you were able to do this work?
4. Give names of clinic, hospitals, sanitarium or other institutions where you received treatment and indicate dates of confinement.
   (a) __________ __________
   (b) __________ __________
   (c) __________ __________
5. Names of all physicians who have attended to you for your present illness/injury and indicate inclusive dates.
   (a) __________ __________
   (b) __________ __________
   (c) __________ __________
6. (a) Were you confined to bed at home? If so, indicate inclusive dates. __________
   ____
   (b) State briefly your present daily routine of life.
   ____
   ____
   (c) Has there been any improvement in your condition? __________ If so, please describe. __________
   ____
7. Have you done any work since you gave up your usual occupation?
8. When do you expect to return to work?
9. If you were unable to perform your regular duties, could you you do light clerical or shopwork, light housework, light outdoor work, chores etc.?
10. Do you have any claim because of your illness or injury against any person or company? Give names and their addresses.

(Please use reverse side for additional information which would help us evaluate your claim)

Signed at ______________ this ________ day of ______________, 20 ____ .

______________	______________	______________
WITNESS	ADDRESS OF WITNESS	INSURED

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

Notary Public
My commission expires on
____

INSURED'S AUTHORIZATION

I HEREBY AUTHORIZE any physician or other person or any hospital, sanitarium or institution to furnish THE INSULAR LIFE ASSURANCE COMPANY, LTD., any information that may be required concerning my illness or disability.

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	INSURED