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

Claimant's Statement
(I-Shield Claim Form I-B)

INSTRUCTIONS:

1. This form is to be accomplished completely (if not applicable, please write N/A in the space provided for) by the BENEFICIARY (I-Shield Claim Form I-B) and must be submitted together with the PHYSICIAN'S STATEMENT (I-Shield Claim Form III).
2. The following items should also be submitted and will form part of the I-Shield Claim forms:
   2.1. Patient's Admitting History, Clinical History and Physical Examination, Discharge Clinical Summary, Results of any Medical Examinations/Laboratory Tests;
   2.2. Copy of the police report; or
   2.3 Sworn statement of at least one eyewitness; or
   2.4 Autopsy Report, if any. Other applicable documents as specified in this I-Shield Claim form.
3. Submit all required documents to 18TH Floor, Customer Care Unit, The Insular Life Assurance, Company, Ltd., Insular Life Corporate Centre, Insular Life Drive, Filinvest Corporate City, Alabang, 1781 Muntinlupa or to any Insular Life Insular Life District Offices.

To: The Insular Life Assurance Company, Ltd.

I hereby claim for death benefit under the policy/policies of this Company, numbered as follows: _____

A. Declaration:

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. Name of Claimant:

_____

Surname | Given Name | Suffix (Sr./Jr./etc.)

_____

Mother's Maiden Surname | Given Name

2. Present Address:

_____

House No. | Street | Barangay | Town/Municipality

_____

City/Province | Country | Zip Code

3. Residence Tel No.	4. Office Tel. No.	5. Mobile No.
6. Email Address	7. Date of Birth:	8. Nationality:

9. (a) Valid Identification Presented:
( ) BIR-TIN ( ) SSS ( ) GSIS ( )UMID ( ) Others_____
(b) Identification Number: _____

10. BIR-TIN/SSS/GSIS Number: _____

11. Source of Funds (select at least one):
( ) Business Income ( ) Family Income ( ) Income from Employment ( ) Savings ( ) Others _____

12. Details of Source of Funds (Name of business, employer, etc.):

13. If you are also 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 BIRTH DATE RELATION TO MINOR

_____
_____
_____
_____

14. 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?	15. Is/Are the same minor/s under your actual custody and support?
( ) Yes ( ) No	( ) Yes ( ) No

INFORMATION ON THE DECEASED INSURED

1. Name of Claimant:

_____
Surname Given Name Suffix (Sr./Jr./etc.)

_____
Mother's Maiden Surname Given Name

2. Present Address:

_____
House No. Street Barangay Town/Municipality

_____
City/Province Country Zip Code

3. a. Birthdate of deceased:_____ b. Birthplace of deceased:_____

4. a. Date of death:_____ b. Cause of death:_____

c. Place of Death:_____
Barangay Town/Municipality City/ Province Country

d. Date of internment:_____ e. Place of interment:_____
Month Date Year

5. Other Policies of Insured with us or with other Insurance Companies:

Policy Number	Name of Insurance Company	Amount of Insurance

6. Details on occupation of deceased insured *(if more than one, state all)*

a. Job Title/Position: _____

b. Brief description of job assignment: _____

_____

_____

_____

c. Employer's Name: _____

e. Nature of Employer's Business: _____

_____

_____

_____

7. a. Did insured hold any elective position in government at time of accident? _____Yes _____No	b. If yes, please state position and Title: _____ _____	c. Tenure of office: From: _____ To: _____

INFORMATION ON THE ACCIDENT (Please answer each question, if not applicable, write NA

1. Date and time of accident _____ _____ _____ _____ Month Day Year Time	2. Place of accident: _____ Name of Street/ Highway City or Municipality Province Country

3. Give complete history of accident or how the injury was sustained:

_____

_____

_____

4. What was the insured doing before the accident happened? Where was the insured before the accident? Who was with insured before the accident?

_____

_____

_____

5. If insured is employed, was he at work at time of accident? If yes, give details:

_____

_____

_____

6. Please answer if claim is due to a vehicular accident

a. During the accident, was insured a passenger, driver or pedestrian? _____

b. If driving or riding a motorcycle, was insured wearing a helmet? Yes_____No _____

c. If driving or riding a vehicle, was insured wearing a seatbelt? Yes_____No _____

d. Please fill up the following:

<table>
<tr><th>If traveling by land</th><th colspan="2">If traveling by plane or ship</th></tr>
<tr><td>Route:</td><td colspan="2">Name of Airline/Shipping Company:</td></tr>
<tr><td>Name of driver:</td><td colspan="2" rowspan="3">Office address of Airline/Shipping Company:</td></tr>
<tr><td>Vehicle type:</td></tr>
<tr><td>Plate number:</td></tr>
<tr><td>Registration year:</td><td>Telephone nos.</td><td>E-mail address</td></tr>
<tr><td>Please attach photocopies of Official Receipt, Certificate of Registration, Driver's License if the Insured is the one driving (plasticized and renewal receipt of payment)</td><td colspan="2">Please attach a certification from the Airline/Shipping Company stating that insured was included in the list of passengers manifest.</td></tr>
</table>

7. Was a police investigation conducted on the accident? If yes, please submit certified true copy of the police investigation report and copy (ies) of statement(s) of witness (es). If "No", explain why no such investigation was made.

_____

_____

_____

8. Give the names and addresses of the physicians who attended to the Insured for injuries sustained from the accident:

Name of physician	Addresses of Hospital/Clinic	Date of attendance					
		From			To		
		Month	Day	Year	Month	Day	Year

9. Names, addresses and contact numbers of witnesses to the accident:

Name of witness	Addresses /Contact numbers

10. If confined in hospital, please provide:

Name of Hospital	Address	Date of confinement					
		From			To		
		Month	Day	Year	Month	Day	Year

11. Was there an autopsy or other post-mortem examination made on the body of the deceased?

_____

_____

12. If no autopsy was done, please explain why?

_____

_____

INFORMATION ON DECEASED INSURED'S PAST MEDICAL HISTORY (Please answer each question, if not applicable, write N/A)

1. Give names and addresses of other physicians, if any, who had attended to the INSURED for other previous illnesses, diseases or injuries during the past two (2) years.

			Dates					
			From			To		
			Month	Day	Year	Month	Day	Year

2. Names of DECEASED INSURED'S Family Physician

Name of Physician	Addresses /Contact numbers

A. Data Privacy Statement

I understand that as a financial institution, Insular Life is subject to existing and future government regulations. I therefore agree to be bound by all applicable domestic and international laws in relation to any matter including but not limited to anti-money laundering, tax monitoring and data privacy.

In this connection, I authorize Insular Life to process my personal and sensitive personal information including but not limited to its collection, use, retention, destruction or sharing with Insular Life subsidiaries, affiliates, agents, authorized third parties, and any medical information sharing facility for any legitimate purpose, including but not limited to underwriting and administration of insurance policies and insurance claims, marketing and promotion of products, market research, data analytics and automated processing systems, internal and external audit.

I also confirm that I have sought the consent of the insured and/or the beneficiary/ies in sharing his/her personal and sensitive personal information, as may be applicable.

I hold Insular Life free and harmless from any liability that may arise from any collection, use, retention, destruction or sharing of said information as mentioned above.

B. Authorization

In relation to the claims application for the illness, injury and/or death of the Policy Owner or Insured under this Policy, I hereby authorize The Insular Life Assurance Co., Ltd. ("Company") or its authorized representative to secure any information and/or record belonging to the Policy Owner or Insured, as the case may be, under this Policy pertaining to the following:

1. Financial, employment/business/livelihood;
2. Health, both physical and mental;
3. Lifestyle;
4. Court (criminal, civil or administrative) records;
5. Personal; or
6. Other circumstances

from any of his/her employers, business partners, co-employees, staff, consultants, physicians, or from any hospital, clinic, health maintenance organization, diagnostic center, laboratory or any similar medical facility, any private or government agency or institution, organization, insurance industry association or from any individual person that may have knowledge, access to or custody of any such information or record.

I likewise authorize the foregoing individuals or entities that have/had knowledge, access to or custody of any of the abovementioned information or record to disclose and release the same to Insular Life or its representative and further hereby discharge them from any responsibility, obligation or liability arising out of or in connection with such disclosure and release of the information or record.

Done at_____ this_____ day of_____, 20 _____

_____	_____
NAME AND SIGNATURE OF WITNESS	NAME AND SIGNATURE OF CLAIMANT
_____	_____
ADDRESS OF WITNESS	ADDRESS OF CLAIMANT
	_____
	CONTACT NOS. OF CLAIMANT

SUBSCRIBED AND SWORN to before me_____, who exhibited to me his/her Govt. issued ID/Passport No._____, issued at_____, on_____

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

Notary Public
My commission expires on
_____

WARNING: It is unlawful (a) to present or cause to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and (b) to 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.)

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