

Claimant's Statement

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: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">NAME OF COMPANY</th> <th style="text-align: center; border-bottom: 1px solid black;">POLICY NO.</th> <th style="text-align: center; border-bottom: 1px solid black;">AMOUNT OF INSURANCE</th> </tr> </thead> <tbody> <tr><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td></tr> <tr><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td></tr> </tbody> </table>	NAME OF COMPANY	POLICY NO.	AMOUNT OF INSURANCE						
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) Place of Death: (c) Cause of Death: (d) Date and Place of Interment:	(b) Please state your relationship to the deceased such as son, daughter, father, mother, etc. (c) Are you a designated beneficiary? If answer is NO please state in what capacity you are filing this claim? (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.) <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;">NAME OF MINORS</th> <th style="text-align: center; border-bottom: 1px solid black;">BIRTHDATE</th> <th style="text-align: center; border-bottom: 1px solid black;">YOUR RELATION</th> </tr> </thead> <tbody> <tr><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td></tr> <tr><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;"> </td></tr> </tbody> </table>	NAME OF MINORS	BIRTHDATE	YOUR RELATION						
NAME OF MINORS	BIRTHDATE	YOUR RELATION								
4. (a) Date the deceased first complained of last illness. Give indications: (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? <input type="checkbox"/> YES <input type="checkbox"/> NO Is/Are the same minor/s under your actual custody and support? <input type="checkbox"/> YES <input type="checkbox"/> NO									

(USE REVERSE SIDE FOR ADDITIONAL INFORMATION)

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 _____

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 _____.

 NAME AND SIGNATURE OF WITNESS

 BENEFICIARY/CLAIMANT

 NAME AND SIGNATURE OF WITNESS

 RELATIONSHIP TO THE DECEASED

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.)