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 • 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.

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.)

To: The Insular Life Assurance Company, Ltd.

I hereby claim for death benefit under the policy/policies 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. Name of Claimant:

Surname	Given Name	Middle Name	Suffix (Sr./Jr., etc)

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. 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	BIRTH DATE	RELATION TO MINOR

8. 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?	9. Is/Are the same minor/s under your actual custody and support?
_____Yes _____No	_____Yes _____No

INFORMATION ON THE DECEASED INSURED

1. a. Full name of deceased:

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

Mother's Maiden Name	Surname	Given Name

b. Residence of deceased:

House No.	Street	Barangay	Town/Municipality

City/Province	Country	Zip Code

2. a. Birthdate of deceased: _____ b. Birthplace of deceased: _____
Month Date Year

3. a. Date of death: _____ b. Cause of death: _____
Month Date Year

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

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

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

Policy Number	Name of Insurance Company	Amount of Insurance

5. 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: _____

d. Employer's Address:

_____
House No. Name of Street/ Highway Town/Municipality

_____
City/Province Country Zip Code

e. Nature of Employer's Business: _____

_____

_____

_____

6. 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 N/A)

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

Done at_____this_____day of_____, 20 _____

_____

Name and Signature of Claimant

_____

Name and Signature of Witness

_____

Address of Witness

SUBSCRIBED AND SWORN to before me this_____day of_____, 20_____, by the above claimant who exhibited to me his/her government issued ID/Passport No._____, issued at_____on_____.

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

C L A I M A N T ' S A U T H O R I Z A T I O N

To Whom It May Concern:

This authorizes The Insular Life Assurance Company, Ltd. or its authorized representative to secure whatever information or record you may have regarding the disease or injury for which the deceased, has been 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 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