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

Insured's Statement – Disability Claim

I hereby make claim under the policy/ies of this Company, numbered as follows:_____. All of the following answers and statements are true, complete and correct.

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.

NOTE: *To help us in the evaluation of your claim, please use reverse side for answers requiring additional information and identify your answers with corresponding item numbers.*

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 authorities? _____If so, please attach Police Investigation Report.

3. Give complete history of your illness or how injury was sustained (Use reverse side if necessary).

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 you for your present illness/injury and indicate inclusive dates.

(a) _____ _____

(b) _____ _____

(c) _____ _____

6a. State briefly your current daily activities/routine from date of your disability, or for request of extension, from date of your last claim

List of Activities	From	To

6b. Has there been any improvement in your condition from date of disability or date of last claim?_____. Please describe and state date improvement was noticed.

7. What was your work immediately prior to your disability? Describe nature of work and scope of duties and responsibilities.

8. When was the last time that you were able to perform this work?

9. When do you expect to return to work?

10. Have you done any work since you gave up your usual occupation?

11. If you were unable to perform your regular duties, could you do light clerical or shop work, light housework, light outdoor work, chores etc.? If yes, please provide details.

12. Do you have any claim against any person or company because of this illness or injury? Give names and their addresses.

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.)

Signed at_____this_____day of_____, 20_____.

_____
NAME AND SIGNATURE OF WITNESS

_____
ADDRESS OF WITNESS

_____
NAME AND SIGNATURE OF INSURED

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
_____

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_____.

_____
NAME AND SIGNATURE OF WITNESS

_____
NAME AND SIGNATURE OF INSURED