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

Insured's Statement Dread Disease Claim

To The Insular Life Assurance Company, Ltd.

I hereby make claim under the policy or policies 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 constitute an admission that there is any insurance in force.

1. (a) Name
Given Name Surname Suffix
(b) Address
(c) Contact No/s.
(d) Date & Place of Birth
(e) Occupation
2. Date & Place of Commencement of Illness
3. Date first symptoms discovered
4. Give complete history of your illness. (Use reverse side if necessary)
5. Give names of doctors, clinics, hospitals or other institutions where you received treatment and or confinement related to your Dread Disease Claim.

Date	Name of Doctors & Hospital	Treatment/ Diagnosis	Confinement (if any)

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.)

NOTE: IN CASE YOU ARE IN POSESSION OF REPORTS FROM ANY DOCTOR OR HOSPITAL ABOUT TREATMENT RECEIVED IN CONNECTION WITH THE DREAD DISEASE SUFFERED, PLEASE LET US HAVE A COPY OF THIS REPORT.

Signature of Insured:_____ Date: _____

Name and Signature of Witness:_____ Date: _____

SUBSCRIBED AND SWORN to before me this_____day of_____20___, by the above claimant who exhibited to me his/her Govt. issued ID/Passport No._____, issued at_____on_____.

Doc. No. _____
Book No. _____
Page No. _____
Series No. _____

NOTARY PUBLIC
My Commission expires on
_____

AUTHORIZATION

To Whom It May Concern:

This authorizes the Insular Life Assurance, Co., Ltd. or its authorized representative to secure whatever information or record you may have regarding my medical history, accident, and hospital confinement. This authorization is being made in connection with my claim on the insurance policy issued by the said insurance company. I agree that a photocopy of this authorization shall be considered valid.

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.

Signature of Insured:_____ Date: _____

Name and Signature of Witness:_____ Date:_____