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.: 582-1818 • Fax: 771-1717

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:	5. If deceased was insured with other companies, please state the following: NAME OF COMPANY / POLICY NO. / AMOUNT OF INSURANCE
(b) Residence of the deceased:	
(c) Occupation:	
2. (a) Birthdate and Birthplace of the deceased:	6. (a) What is your date of birth? If a married minor, please submit marriage certificate:
3. (a) Date of Death:	(b) Please state your relationship to the deceased such as son, daughter, father, mother, etc.
(b) Place of Death:	(c) Are you a designated beneficiary? If answer is NO please state in what capacity you are filing this claim?
(c) Cause of Death:	(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.) NAME OF MINORS / BIRTHDATE / YOUR RELATION
(d) Date and Place of Interment:	
4. (a) Date the deceased first complained of last illness. Give indications:	
(b) Names and addresses of all physicians who attended the deceased:	(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? ☐ YES ☐ NO Is/Are the same minor/s under your actual custody and support? ☐ YES ☐ NO
(c) Names and addresses of all medical institutions or hospitals where deceased was confined:	

(USE REVERSE SIDE FOR ADDITIONAL INFORMATION)

Dated at _____ this _____ day of _____ , 20 _____

_____ WITNESS

_____ ADDRESS OF WITNESS

_____ NAME AND SIGNATURE OF CLAIMANT

_____ ADDRESS OF CLAIMANT

_____ CONTACT NOS. OF CLAIMANT

SUBSCRIBED AND SWORN to before me this _____ day of _____ , 20 _____, by the above claimant who exhibited to me his/her Residence Certificate No. A _____ , issued at _____ on

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

Notary Public
My commission expires on
_____

CLAIMANT'S 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 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 CLAIMANT

_____ WITNESS

_____ RELATIONSHIP TO THE DECEASED