



INSURED'S STATEMENT FOR DREAD DISEASE CLAIMS

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	2. (A) NATURE OF THE CLAIM		
(B) ADDRESS			
(C) CONTACT NO.			
(D) DATE & PLACE OF BIRTH			
(E) OCCUPATION			
3. (A) DATE & PLACE OF COMMENCEMENT OF ILLNESS			
4. (A) GIVE COMPLETE HISTORY OF YOUR ILLNESS. (USE REVERSE SIDE IF NECESSARY)			
5. (A) GIVE NAMES OF DOCTORS, CLINICS, HOSPITALS OR OTHER INSTITUTIONS WHERE YOU RECEIVED TREATMENT AND OR CONFINEMENT RELATED TO YOUR DREAD DISEASE			
<u>DATE</u>	<u>NAMES OF DOCTORS & HOSPITALS</u>	<u>TREATMENT/DIAGNOSIS</u>	<u>CONFINEMENT (IF ANY)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IN CASE YOU ARE IN POSSESSION 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.

DATED AT _____ THIS _____ DAY OF _____, 20_____

WITNESS

INSURED

ADDRESS OF WITNESS

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

INSURED'S AUTHORIZATION

I HEREBY AUTHORIZE any physician or other person or any hospitals, 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_____

IL/ARPDS/DDRCF - 0893

WITNESS

INSURED