

**CLAIMANT'S STATEMENT**

TO : ASIANLIFE & GENERAL ASSURANCE CORP

I hereby claim for benefit under the Insurance Policy(ies) of this Company numbered \_\_\_\_\_ . All the following answers and statements are true, correct and complete according to my personal knowledge and belief. I understand that furnishing of this form and other claim forms by the Company does not constitute an admission that there is any insurance in force nor as a waiver of the Company's rights to defense.

1. (a) Full Name of the Deceased: \_\_\_\_\_  
 (b) Residence of the Deceased: \_\_\_\_\_  
 (c) Name and Address of Employer: \_\_\_\_\_  
 (d) Date deceased last attended his/her usual work: \_\_\_\_\_  
 (e) Occupation at date of death: \_\_\_\_\_

2. (a) Date of Birth: \_\_\_\_\_ (b) Place of Birth: \_\_\_\_\_

3. (a) Date of Death: \_\_\_\_\_ (b) Place of Death: \_\_\_\_\_  
 (c) Cause of Death: \_\_\_\_\_  
 (d) Date and Place of Interment: \_\_\_\_\_

4. (a) Date deceased first complained or showed symptoms of last illness: \_\_\_\_\_  
 (b) Date deceased first consulted a physician \_\_\_\_\_  
 (c) Names and addresses of all physicians who attended the deceased for the injuries sustained or during his last illness and during the three years immediately preceding it and/or hospitals or other institutions where the deceased was confined or received treatment within the last three (3) years.

Name of Physician and Hospital	Address	Date of Confinement	Disease/Illness
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Was death due to Suicide, Homicide, Accident, Occupational Accident? If so, described briefly:  
 \_\_\_\_\_

6. If deceased was insured with other Companies, please state:

Name of Company	Policy Number	Amount of Insurance
_____	_____	_____
_____	_____	_____
_____	_____	_____

**TO WHOM IT MAY CONCERN**

This authorizes AsianLife & General Assurance Corp. or its authorized representative to secure whatever information or records you have regarding the illness or injury for which patient \_\_\_\_\_ 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 authorized member of your staff from any responsibility or obligation in connection with the release of such record or information.

A facsimile or reproduction of this Authorization shall be valid and binding as the original.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
 PRINTED NAME OVER SIGNATURE OF WITNES:

\_\_\_\_\_  
 PRINTED NAME OVER SIGNATURE OF CLAIMANT  
 RELATION TO THE DECEASED \_\_\_\_\_

7. Are you a designated beneficiary? Yes \_\_\_\_\_ No \_\_\_\_\_. If no, please state in what category you are filing this claim. \_\_\_\_\_

8. What is your date of birth? \_\_\_\_\_ (If married, please submit Marriage Contract.)

9. If you are filing this claim in behalf of minor beneficiaries, please give names and dates of birth and your relation to them. (State such as father, mother, grandfather, etc.)

Minor's Name	Date of Birth	Relationst
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. 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 \_\_\_\_\_.

11. Is / Are the same minor(s) under your actual custody and support? Yes \_\_\_\_\_ No \_\_\_\_\_

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

\_\_\_\_\_  
SIGNATURE OVER PRINTED NAME OF WITNESS

\_\_\_\_\_  
SIGNATURE OVER PRINTED NAME OF CLAIMAN

**ACKNOWLEDGEMENT**

SUBSCRIBE AND SWORN to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ by the above claimant who exhibit to me his/her Residence Certificate No. \_\_\_\_\_ issued at \_\_\_\_\_ on \_\_\_\_\_.

Loc. No: \_\_\_\_\_ Book No. \_\_\_\_\_

Page No. \_\_\_\_\_ Series of \_\_\_\_\_

NOTARY PUBLIC

My commission Expires on \_\_\_\_\_