3rd Flr.. Morning Star Center,
347 Sen Gil Puyat Avenue, Makati City
Tel. No. 890-1758* Fax No. 895-8524

CLAIMANT'S STATEMENT

TO : ASIANLIFE & GENERAL ASSURANCE CORP.

I hereby claim for benefit under the Insurance Certificate/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.

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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:_______________________________________

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3. (a) Date of Death:_____________________ (b) Place of Death:______________________________________
   (c) Cause of Death:____
   (d) Date and Place of Interment:____

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4. (a) Date deceased first complained or showed symptoms of last illness:____________________________
   (b) 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

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5. Was death due to Suicide, Homicide, Accident, Occupational Accident? If so, described briefly:
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6. If deceased was insured with other Companies, please state:

Name of Company	Certificate/Policy Number	Amount of Insurance

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TO WHOM IT MAY CONCERN

This authorizes Asianlife & General Assurance Corporation or its authorized representative to secure whatever information or records you have regarding the illness or injury for which the deceased ____________________________________ has been treated or examined. This authorization is being made in connection with any claim on the insurance Certificate/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.

Signed at _____________________ this___________day of ___________________, 19___________.

____
PRINTED NAME OVER SIGNATURE OF WITNESS

____
PRINTED NAME OVER SIGNATURE OF CLAIMANT
RELATION TO THE DECEASED _________________

*** see back page ***

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

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

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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	Relantionship
______________________________	________________________	_________________________
______________________________	________________________	_________________________
______________________________	________________________	_________________________
______________________________	________________________	_________________________

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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___________.

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11. Is / Are the same minor(s) under your actual custody and support? Yes___________ No_________

Signed at_________________________ day of ___________________, ___________.

____ SIGNATURE OVER PRINTED NAME OF WITNESS

____ SIGNATURE OVER PRINTED NAME OF CLAIMANT

A C K N O W L E D G E M E N T

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 ___________________