

POLICYHOLDER'S STATEMENT

POLICYHOLDER:	MASTER POLICY NUMBER :		
NAME OF INSURED:	CERTIFICATE NUMBER :		
BEFORE FILLING UP THIS FORM, READ INSTRUCTIONS AT THE BOTTOM HEREOF, EVERY QUESTION MUST BE DISTINCTLY AND FULLY ANSWERED.			
1. Full Name of Deceased :			
2. (a) Date of Birth :	(b) Place of Birth :		
3. (a) Amount of Insurance :	(b) Effective Date :		
4. (a) Date of Death :	(b) Place of Death :		
(c) Age at Death :	(d) Cause of Death :		
(e) Date of Interment :	(f) Place of Interment :		
5. (a) Occupation before Death :	(b) Date Employed :		
(c) Date Employment was terminated :			
(d) Date on which deceased last worked full time :			
6. TO BE ANSWERED IF POLICYHOLDER IS AN ASSOCIATION, UNION, TRUSTEE, CLUB., ETC.			
(a) Date of Membership of the deceased :			
(b) Was deceased in good standing at the time of death ?			
(c) Date Membership of deceased was terminated :			
7. Date deceased first complained or showed symptoms of last illness :			
8. Date deceased first consulted a physician for last illness:			
9. (a) Was death due to / / Suicide / / Homicide / / Occupational Accident ?			
(b) Describe fully the particulars as to the place it occurred and how it occurred : _____			
10. Names and addresses of all physicians who attended the deceased during last illness and within the last three years before the last illness preceding it and / or hospitals or other institution in which the deceased was confined or received treatment within the last three years.			
<u>Name of Physician/ Hospital/Institution</u>	<u>Address</u>	<u>Date of Attendance</u>	<u>Disease Condition</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
<u>NAME OF BENEFICIARIES</u>	<u>RELATIONSHIP</u>	<u>ADDRESS</u>	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
12. Do you recommend payment of this claim ? _____			
13. Remarks : _____			
Dated at _____ this _____ day of _____ 19 _____ .			
WITNESSED BY :			
_____ SIGNATURE OVER PRINTED NAME		_____ SIGNATURE OVER PRINTED NAME	
		_____ Position / Tit	
INSTRUCTIONS			
This Statement should be fully completed and signed by the Authorized Officer of the Policyholder. The answers to Question No. 6 convey additional information necessary on a Master Policy issued to an Association, Union, or for Trustee Plan.			
If the Plan includes DEPENDENT'S COVERAGE, this form may be used in reporting the death of the Dependent by answering all the Questions applicable to the insured individual and by stating the word "Dependent" on the space provided for remarks			