

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

**CERTIFICATE OF CLAIMANT**  
**DISABILITY CLAIM FORM NO. 1**

This form must be answered fully by the insured or if unable, by his duly appointed Guardian or Beneficiary, or nearest relative may do so.

POLICYHOLDER : \_\_\_\_\_ MASTER POLICY NO. \_\_\_\_\_

1. Full Name : \_\_\_\_\_ Certificate No. \_\_\_\_\_
2. Present Address : \_\_\_\_\_
3. Date of Birth : \_\_\_\_\_ Place of Birth: \_\_\_\_\_
4. Occupation : \_\_\_\_\_
5. When did you feel the first indication of failing health ? \_\_\_\_\_
6. What were the indications ? \_\_\_\_\_
7. When did you first take treatment for your present illness ? \_\_\_\_\_
8. What was the treatment done ? \_\_\_\_\_
9. Date of commencement of total disability ? \_\_\_\_\_
10. Give a complete history of your illness since becoming totally disabled. \_\_\_\_\_
11. Give name of all physicians who attended you for your present illness.

**N A M E**

**DATE OF ATTENDANCE**

_____	_____
_____	_____
_____	_____

12. Give names of any hospital, sanitarium, or other institutions in which you have received treatment.

**NAME OF HOSPITAL**

**DATE OF CONFINEMENT**

_____	_____
_____	_____
_____	_____

13. Were you confined ? YES / / NO / / If so, when ? \_\_\_\_\_
  14. Were you confined to your home, YES / / NO / / If so, when? \_\_\_\_\_
  15. If you are not confined to your home, why are you unable to work ? \_\_\_\_\_
  16. State briefly your present daily routine and mode of life. \_\_\_\_\_
  17. Describe any improvement in your condition. \_\_\_\_\_
  18. Have you any operations ? If so, give details. \_\_\_\_\_
  19. What illnesses have you had previous to your present disability? \_\_\_\_\_
  20. Who is the doctor who you usually called for consultation/treatment? \_\_\_\_\_
  21. Who are the other doctors not mentioned above who have treated you or been consulted by you? \_\_\_\_\_
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22. What is the last date on which you were able to do your usual work ? \_\_\_\_\_
  23. What was the nature of the work you were doing immediately prior to becoming totally disabled ? \_\_\_\_\_
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**CERTIFICATE OF CLAIMANT (DISABILITY CLAIM FORM NO. 1)**

24. If you are not able to perform your regular duties, could you do lighter work of some sort, such as light clerical or shopwork, light housework, light outdoor work, chores, etc.? If so, please state which type.

25. Have you done any work whatsoever since giving up your usual occupation? If so, please give full details.

26. When do you expect to be able to return to work ? \_\_\_\_\_

27. Have you any health or accident policies which contain disability benefits or other life insurance policies? If so, please give details.

<b>NAME OF COMPANY</b>	<b>YEAR OF ISSUE</b>	<b>AMOUNT OF MONTHLY DISABILITY BENEFIT</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

28. Have any companies ever declined an application for disability insurance benefits on your life ? If so, please name company/ies.

29. Have you ever received a pension from any government? Or benefit from any life, accident or health company or benefit society or Workmen's Compensation? If so, state when and from what source.

I, the undersigned do solemnly declare the foregoing answers and statements are full, complete and true, and further agree that the furnishing of this form or any other forms supplemental thereto by the Company, shall not constitute an admission by it that there is any insurance in force on my life or a waiver of any of its rights or defense.

I HEREBY AUTHORIZE any physician or other person or any hospital, sanitarium, other institution to furnish to the ASIANLIFE & GENERAL ASSURANCE CORP. any information that may be required concerning my illness.

DATE : \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF INSURED/CLAIMANT