



CLAIMANT'S STATEMENT

TO: ETIQA PHILIPPINES

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.

- 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) 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 Disease/Illness	Hospital Address	Date of Confinement
_____	_____	_____
_____	_____	_____
_____	_____	_____

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	Certificate/Policy Number	Amount of Insurance
_____	_____	_____
_____	_____	_____
_____	_____	_____

TO WHOM IT MAY CONCERN

This authorizes Etiqa Philippines 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 _____, _____.

PRINTED NAME OVER SIGNATURE OF

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	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 _____ day of _____, _____.

SIGNATURE OVER PRINTED NAME
OF WITNESS

SIGNATURE OVER PRINTED NAME
OF CLAIMANT

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 _____

Form No. GID-115