



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.

Table with 4 columns: 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:

Table with 3 columns: 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 WITNESS

PRINTED NAME OVER SIGNATURE OF CLAIMANT RELATION TO THE DECEASED



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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
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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 _____.

Signed at _____ day of _____, _____.

Minor's Name	Date of birth	Relationship
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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

IMPORTANT NOTICE

"Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both at the discretion of the court to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribe any writing with intent to present or use the same, or to allow it to be presented in support of any claim."