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?_____

_____

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 ?

_____

* * * see back page * * *

Etiqa Life and General Assurance Philippines, Inc.
(Formerly: AsianLife and General Assurance Corporation)
2nd and 3rd Floor Morning Star Center
347 Sen. Gil Puyat Avenue, Makati City 1209
Tel. No: (632) 8890-1758
www.etiqa.com.ph

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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.

NAME OF COMPANY	YEAR OF ISSUE	AMOUNT OF MONTHLY DISABILITY BENEFIT

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 ETIQA PHILIPPINES any information that may be required concerning my illness.

DATE : _____

_____
SIGNATURE OF INSURED/CLAIMANT

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