CLAIMANT'S STATEMENT — DISABILITY CLAIM

IMPORTANT: Every question must be completely and distinctly answered to facilitate claims processing. Philippine Life Financial Assurance reserves the right to require further information should it be deemed necessary.

1.	Policy Number / s			
2.	Insured's Full Name			
	Payor's Full Name			
3.	Insurance Policy Number			
4.	Insured's Date of Birth			
5.	Insured's Address			
6.	Claimant's Full Name			
7.	Claimant's relation to the insured			
8.	Insured / Claimant's Contact Nos.			
9.	Describe first symptoms of illness or injury:			
10.	Nature of illness or injury:	Date of injury or first noticed symptoms of illness:	Date first treated for this illness or injury:	
11.	Date insured became unable to work because of this illness or injury:	Was illness or injury related to the insured's employment? If yes, please provide details:		
12.	Did the insured experience the same or similar condition in the past? If yes, please provide details:			
13.	Has the insured engage in any other work since illness or injury began? If yes, please provide details:			
14.	Date insured returned to work:	Date insured expect to return to work:		
15.	Give insured's exact job title and duties of occupation when the illness or injury began:			
16.	Names and addresses of all physicians that treated the insured for this illness / injury.			
	Name of Physician / Hospital / Institution	Address	Contact Numbers	Dates Attended
17.	Describe any other income that the insured are receiving or are entitled to receive as a result of this disability (SSS/GSIS/ECC/Life/Health Insurance/ Accident Insurance):			
	Nature of Claim	Name of Company	Amount Received	Date Payment Began
18.	Do you guarantee that all statements and answers made by you in this questionnaire are true and that you have not concealed any material fact from the Insurance Company?			

Having been duly sworn, I/We hereby depose and say that the foregoing statements and answers to the above questions are true and full to the best of my/our knowledge and belief.

Dated at _____ this _____ day of _____, _____.

_____ _____

Signature over Printed Name of Insured — Signature over Printed Name of Claimant

SUBSCRIBED AND SWORN to me before this _____ day of _____, _____, by above claimant who exhibited to me his/her Residence Certificate/Passport/PRC/Driver's License No. _____ issued at _____ on _____.

Doc. No. _____
Page No. _____
Book No. _____
Series of _____

NOTARY PUBLIC

CERTIFICATE OF INSURED / CLAIMANT'S AUTHORIZATION

I authorize any physician, medical practitioner, clinic, hospital, other health facility, insurance company, government offices or employer to release all medical and non-medical information about me in its possession to PHILIPPINE LIFE FINANCIAL ASSURANCE CORPORATION or its authorized representatives.

A photographic copy of this authorization is valid as the original.

_____ _____

Date and Place of Signing — Signature over Printed Name of Insured /Claimant