



## CLAIMANT'S STATEMENT – DEATH CLAIM

### LIFE INSURED'S INFORMATION

Last Name		First Name		Middle Name	
Address					
Date of Birth (MM/DD/YYYY)		Place of Birth		Nationality	Age
Occupation	Name of Employer		Address		
Date of Death			Place of Death		
Cause of Death					

**PLEASE STATE THE NAME AND ADDRESS OF ALL PHYSICIANS INCLUDING MEDICAL INSTITUTIONS WHERE LIFE INSURED HAD RECORD OF CONSULTATION/S AND CONFINEMENT/S:**

Date of Attendance	Name of Physician/Address	Medical Institution/Address	Diagnosis/Treatment/Procedure

**OTHER LIFE AND ACCIDENT INSURANCE ON THE LIFE OF THE INSURED:**

Insurance Company	Date of Policy	Amount of Insurance

### CLAIMANT'S INFORMATION

Last Name		First Name		Middle Name	
Address					
Date of Birth (MM/DD/YYYY)		Place of Birth		Nationality	Age
Contact Details: Home		Office		Cellphone	
Fax		E-mail Address			
Relationship to the Life Insured					

### CLAIMANT'S DECLARATION AND AUTHORIZATION

In my capacity as beneficiary of the Policy (or trustee of the minor beneficiary), I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, entity or employer, having information available as to diagnosis, treatment, results and prognosis, with respect to the physical or mental examination or condition of the insured \_\_\_\_\_ to give to **GENERALI LIFE ASSURANCE PHILIPPINES, INC., (GLAPI)** or its legal representative, any and all information, or any other information or record it may need to process the claim on the deceased life insured.

The authority herein given pertains to all records containing medical or non-medical data including, but not limited to, mental and dental care, drug or alcohol use, prescribed drugs, information about communicable diseases, and any employment and insurance coverage information.

I also authorize **GLAPI** to obtain an investigative report from its duly authorized inspection agency which will provide any applicable information concerning this claim for insurance benefits on the life of the insured \_\_\_\_\_.

I agree that a photographic copy of this Authorization shall be valid as the original.

This authorization discharges Generali Life Assurance Philippines, Inc. or any of its authorized representative from any responsibility or obligation in connection with the release of such record or information.

As described above and for that purpose, I attest that the foregoing answers are true and correct and complete to the best of my knowledge and belief.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OVER PRINTED NAME OF WITNESS

\_\_\_\_\_  
SIGNATURE OVER PRINTED NAME OF CLAIMANT

SUBSCRIBED AND SWORN to me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_ by the above claimant who exhibited to me his/her

Residence Certificate No. \_\_\_\_\_ issued at \_\_\_\_\_ on \_\_\_\_\_.

Doc No. \_\_\_\_\_ Book No. \_\_\_\_\_

Page No. \_\_\_\_\_ Series of \_\_\_\_\_

My Commission expires on \_\_\_\_\_

\_\_\_\_\_  
NOTARY PUBLIC