PHILAM LIFE

CLAIMANT'S STATEMENT

Continuance of Total Disability

Please fully accomplish this form to facilitate processing of your request. If this cannot be accomplished by the owner or insured for reasons of insanity, a duly appointed Guardian or Committee can answer on his behalf. If there is no Guardian or Committee, this document may be executed by the beneficiary or the Insured's/Payor's nearest relative.

1. Full name of Insured/Payor	2. Present Address
3. If confined to a hospital, sanitarium, or other institution, give its name and address	4. Is Insured/Payor confined to his bed or home? State which and from what date. (Month) (Day) (Year)

5. If not confined, how does Insured/Payor spend his time?

6. Describe fully Insured's/Payor's present condition and state how and to what extent he is unable to follow any occupation for remuneration or profit.

7. Is condition showing improvement? (Give full particulars)

8. Give name and address of every physician or practitioner in attendance or consulted

a. Duration From To	b. Name of physician or practioner	c. Address

9. Who was Insured's/Payor's last employer (Give name and address)	10. Is Insured's/Payor's position being held open for him?
11. Has Insured/Payor done any kind of work since commencement of present disability. If so, give full particulars and dates.	12. When is Insured/Payor expected to be able to work?

13. Is Insured/Payor receiving any disability income, allowance or pension from any other source? If so, give name of each Company or source of payment with amounts of weekly or monthly payments.

14. If Insured/Payor is mentally disabled, when was he adjudged insane and who was appointed by the Court as Committee or Guardian for his estate.

I hereby authorize any hospital to which I have been confined and any physician or practitioner who has treated or is now treating me, to impart to THE PHILIPPINE AMERICAN LIFE AND GENERAL INSURANCE COMPANY any information it may desire.

Signtaure of Insured/Payor _____
Residence_____
_____

_____
Signature of Witness over printed name

Telephone / cellphone no. _____
Email _____