PHILAM LIFE

CLAIMANT'S STATEMENT

Total Disability

Please fully accomplish this statement. 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 the Insured/Payor is unable to answer the questions due to a physical condition, this document may be executed by the beneficiary or the Insured's/Payor's nearest relative.

Policy No.	1. Full Name of Insured/Payor	2. Occupation (state exact duties in full)

3. Date of Insured/Payor's birth (Month) (Day) (Year)	4. a. Height _____feet _____inches b. Weight _______pounds c. Have you any scar or deformity? If 'yes', state which and describe it.
5. Describe Insured/Payor's present condition	6. To what extent is Insured/Payor unable to follow any occupation?
7. Give date of injury or beginning of illness causing present condition (Month) (Day) (Year)	8. When was Insured/Payor compelled to give up part of his duties? (Month) (Day) (Year)
9. When was Inured/Payor compelled to give up all of his duties? (Give exact date) (Month) (Day) (Year)	10. How does Insured/Payor spend his time?
11. Has Insured/Payor done any kind of work since commencement of diability? If so, give particulars.	12. When does Insured/Payor expect to return to work?

13. With regard to present affliction, give the name and address of the hospital where Insured/ Payor was confined and of any physician/practitioner who attended to or prescribed to the Insured/Payor

Duration	Name of Physician or practitioner or hospital	Address

14. For what disease, injury, ailment or affliction has Insured/Payor required the services of a physician or practitioner or hospital prior to present affliction

Name of Injury, disease, etc.	Duration From	To	Name of Physician or Practioner or hospital	Address

15. Has either of the Insured/Payor's parents or any of his brothers or sisters or other relatives been afflicted with a similar disease? If so, give particulars.	16. Is Insured/Payor's estate represented by a Committee or Guardian? (If so, furnish copy of appointment)

17. What other Life, Government, Health or Accident Insurance providing for disability benefits have you?

Name of Company	Address	Amount of weekly or monthly indemnity

18. If you have received or are receiving disability pension or indemnity, please give nature, source, amount, duration and date of first payment

Nature	Source (Name of Company/Office)	Amount		1st payment date

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

Dated and signed at ____________________ on __________

Witnessed by: ____________________________________

Signature over printed name

____

Address

____

Signature of Insured/Payor/Guardian/Beneficiary over printed name

____

Address

Telephone/cellphone No : ________________

Email : _______________________________

PHILAM LIFE CUSTOMER CONFIDENTIAL