Generali Life Assurance Philippines, Inc.
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Sen. Gil J. Puyat Ave., Makati City
1227 Philippines
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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	Status
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	Status
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