BPI-PHILAM LIFE ASSURANCE CORP.
A subsidiary of Philam Life and an affiliate of BPI

CLAIMANT'S STATEMENT
DEATH CLAIM

To: BPI-Philam Life Assurance Corp.

I hereby claim the benefit due the undersigned under Policy No. / s_____ and stated that the following answers are true and correct according to my personal knowledge and belief.

I understand that the furnishing of this form and other claim forms does not necessarily mean that the Company is admitting liability under the policy.

1 (a) Full name of the deceased	6 (a) What is your date of birth? (If you are an emancipated minor, please submit marriage contract)
(b) Residence of the deceased	(b) Please state your relationship to the deceased
(c) Occupation of the deceased	(c) Are you the designated beneficiary? If answer is NO, please state in what capacity you are filing this claim?
2 (a) Birthdate & Birth place	
3 (b) Place of Death	(d) If you are filing this claim in behalf of minor beneficiaries, please give their names & dates of birth & your relationship to them Minor's Name _____ Birth Date _____ Relationship _____
(c) Cause of Death	
(d) Date & Place of Interment	
4 (a) Date the deceased first complained of last illness	
(b) Names & Addresses of physicians who attended to the deceased	
(c) Names and addresses of medical institutions or hospitals where the deceased was confined	(e) As father / mother of said minor/s, have you been disqualified by a court of law from exercising the right to administer the property of such minor/s? YES ( ) NO ( ) Is / are the same minor/s under your actual custody & support? YES ( ) NO ( )
5 If deceased was insured with other companies, please state: Name of Company _____ Policy No. _____ Amount _____	7 Are you a US Citizen? If "yes" please submit a W-9 Form YES ( ) NO ( )

Done at _____ this _____ day of _____, 20_____.

Name & Signature of Claimant

Name & Signature of Witness

Address of Claimant

Address of Witness

Telephone Number/Mobile Number of Claimant

Email Address of Claimant

SUBSCRIBED AND SWORN to before me this _____ day of _____, 20_____, by the above claimant who exhibited to me his / her valid identification/s, to wit _____ , _____ , _____.

Doc. No. _____
Page. No. _____
Book No. _____
Series of 20_____

NOTARY PUBLIC
Until Dec. 31, 20 _____
PTR No. _____
Issued on _____
At _____

CLAIMANT'S AUTHORIZATION

TO WHOM IT MAY CONCERN:

Date

I hereby authorize the BPI-Philam Life Assurance Corp. or its representatives to secure whatever medical and personal information or records of _____. This authorization is being made in connection with any claim on the insurance policy issued by said company on the life of the insured.

This authorization discharges your company or any authorized member of your staff from any responsibility or obligation in connection with the release of such record or information.

Name & Signature of Claimant