



THE PHILIPPINE AMERICAN LIFE AND GENERAL INSURANCE COMPANY

Manila, Philippines

CLAIMANT'S STATEMENT REGARDING TOTAL DISABILITY

(Disability Claim Form No. 1)

This form must be answered fully by the Insured/Payor or, if insane, by his duly appointed Guardian or Committee. If, due to physical condition, Insured/Payor is unable to answer the questions, the beneficiary or nearest relative may do so.

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. Descibe 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 exat 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. As regards present affliction, give the name and address of any hospital where confined and of any physician/practitioner who attended to or prescribed for 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 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, give nature, source, amount, duration and date of first payment					
Nature	Source (Name of Company/Office)		Amount	Duration	1st payment date

I herby authorize any hospital to which I have been confined and any physician or 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

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

Address

Address

telephone/cellphone No : _____

Email : _____