



# Claims Form

## YOUR PERSONAL INFORMATION

Mr.  Ms.  Mrs.  
 NAME : \_\_\_\_\_  
 Last Name First Name M.I.  
 Proof of Cover No: \_\_\_\_\_  
 Philippine Address : \_\_\_\_\_  
 Address : \_\_\_\_\_  
 Civil Status :  Single  Married  Separated  Widow/er  
 Birthdate : \_\_\_\_\_ Birthplace : \_\_\_\_\_  
 TIN : - - - Age : \_\_\_\_\_  
 Telephone : Home : - Office : -  
 Fax : - Mobile : -  
 Email Address : \_\_\_\_\_

## YOUR PASSPORT DETAILS

Name(as it appears : \_\_\_\_\_  
 on your passport) Last Name First Name Middle Name  
 Passport No. : \_\_\_\_\_ Issued on: \_\_\_\_\_ at: \_\_\_\_\_

## TYPE OF CLAIM

- |  |   |
|--|---|
| <input type="checkbox"/> Accidental Death            | <input type="checkbox"/> Subsistence Allowance        |
| <input type="checkbox"/> Natural Death               | <input type="checkbox"/> Money Claims                 |
| <input type="checkbox"/> Permanent Total Disablement | <input type="checkbox"/> Compassionate Visit          |
| <input type="checkbox"/> Repatriation Claim          | <input type="checkbox"/> Emergency Medical Evacuation |
| <input type="checkbox"/> Return of Mortal Remains    | <input type="checkbox"/> Medical Repatriation         |

## YOUR AGENCY

Agency Name : \_\_\_\_\_  
 Address : \_\_\_\_\_  
 Association : \_\_\_\_\_  
 Contact Nos. : Tel. : - Fax : -  
 email : \_\_\_\_\_ Agent : \_\_\_\_\_

## YOUR WORK

Company Name : \_\_\_\_\_  
 Address : \_\_\_\_\_  
 Country : \_\_\_\_\_  
 Nature of Business : \_\_\_\_\_ Industry : \_\_\_\_\_  
 Designation : \_\_\_\_\_  
 Monthly Compensation: \_\_\_\_\_ Currency: \_\_\_\_\_  
 T.O.C. : From \_\_\_\_\_ To \_\_\_\_\_ Contract Yr: \_\_\_\_\_

## YOUR BENEFICIARY(IES)

NAME / RELATIONSHIP	DATE OF BIRTH
_____	_____
_____	_____
_____	_____

\*If applicant is single, up to 3 names of immediate family members may be entered.

_____	_____
SIGNATURE	DATE
_____	_____
WITNESS	DATE