

Claimant's Statement (I-Shield Claim Form I-B)

INSTRUCTIONS:

1. This form is to be accomplished completely (if not applicable, please write N/A in the space provided for) by the BENEFICIARY (I-Shield Claim Form I-B) and must be submitted together with the PHYSICIAN'S STATEMENT (I-Shield Claim Form III).
2. The following items should also be submitted and will form part of the I-Shield Claim forms:
 - 2.1. Patient's Admitting History, Clinical History and Physical Examination, Discharge Clinical Summary, Results of any Medical Examinations/Laboratory Tests;
 - 2.2. Copy of the police report;
 - 2.3. Sworn statement of at least one eyewitness;
 - 2.4. Autopsy Report, if any. Other applicable documents as specified in this I-Shield Claim form.
3. Submit all required documents to Customer Care Unit, The Insular Life Assurance, Company, Ltd., Corporate Centre, Insular Life Drive, Filinvest Corporate City, Alabang, 1781 Muntinlupa or to any Insular Life District Offices.

A. Declaration:

I hereby make claim under my I-Shield policy/ies issued by The Insular Life Assurance Co., Ltd.(Company), numbered as follows: _____.

All of the following answers and statements are true, complete, and correctly recorded.

I understand that the furnishing of this form and other claim forms by the Company does not constitute an admission that there is any insurance in force.

1. Name of Claimant:			
Surname	Given Name	Middle Name	Suffix (Sr./Jr., etc)
Mother's Maiden Surname		Given Name	

2. Present address:			
House No.	Street	Barangay	Town/Municipality
City/Province		Zip Code	
3. Residence Tel No.	4. Office Tel. No.	5. Mobile No.	6. Email Address
7. Date & Place of birth:	8. Nationality:	9. a. Valid Identification Document Presented: <input type="checkbox"/> BIR-TIN <input type="checkbox"/> SSS <input type="checkbox"/> GSIS <input type="checkbox"/> UMID <input type="checkbox"/> Others b. Identification Number: _____	
10. BIR-TIN/SSS/GSIS Number: _____	11. Source of Funds (select at least one): <input type="checkbox"/> Business Income <input type="checkbox"/> Family Income <input type="checkbox"/> Savings <input type="checkbox"/> Income from Employment <input type="checkbox"/> Others _____	12. Details of Source of Funds:	

13. If you are also filing this claim in behalf of minor beneficiaries, please give their names and dates of birth and your relation to them below: <i>(State such as father, mother, grandfather, stepfather, etc.)</i>		
NAME OF MINOR	BIRTH DATE	RELATION TO MINOR
_____	_____	_____
_____	_____	_____

14. As father/mother of said minor/s, have you not been disqualified by a court of law from exercising the right to administer the property of such minor/s? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. Is/Are the same minor/s under your actual custody and support? <input type="checkbox"/> Yes <input type="checkbox"/> No
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INFORMATION ON THE DECEASED INSURED

1. a. Full name of deceased:			
Surname	Given Name	Suffix (Sr./Jr., etc)	
Mother's Maiden Name		Given Name	
b. Residence of deceased:			
House No.	Street	Barangay	Town/Municipality
City/Province		Zip Code	

2. a. Birthdate of deceased: _____ b. Birthplace of deceased: _____
 Month Date Year

3. a. Date of death: _____ b. Cause of death: _____
 Month Date Year

c. Place of death: _____
 Barangay Town/Municipality City/ Province Country

d. Date of internment: _____ e. Place of interment: _____
 Month Date Year

4. Other Policies of Insured with us or with other Insurance Companies:

Policy Number	Name of Insurance Company	Amount of Insurance

5. Details on occupation of deceased insured (if more than one, state all)

a. Job Title/Position: _____

b. Brief description of job assignment: _____

c. Employer's Name: _____

d. Employer's Address: _____
 House No. Name of Street/ Highway Town/Municipality
 City/Province Country Zip Code

e. Nature of Employer's Business: _____

6. a. Did insured hold any elective position in government at time of accident? _____ Yes _____ No	b. If yes, please state position and Title: _____	c. Tenure of office: From: _____ To: _____
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INFORMATION ON THE ACCIDENT (Please answer each question, if not applicable, write N/A)

1. Date and time of accident _____ Month Day Year Time	2. Place of accident: _____ Name of Street/ Highway City or Municipality Province Country
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3. Give complete history of accident or how the injury was sustained:

4. What was the insured doing before the accident happened? Where was the insured before the accident? Who was with insured before the accident?

5. If insured is employed, was he at work at time of accident? If yes, give details:

6. Please answer if claim is due to a vehicular accident

a. During the accident, was insured a passenger, driver or pedestrian? _____

b. If driving or riding a motorcycle, was insured wearing a helmet? Yes _____ No _____

c. If driving or riding a vehicle, was insured wearing a seatbelt? Yes _____ No _____

d. Please fill up the following:

If traveling by land		If traveling by plane or ship	
Route:		Name of Airline/Shipping Company:	
Name of driver:		Office address of Airline/Shipping Company:	
Vehicle type:			
Plate number:			
Registration year:		Telephone nos.	E-mail address
Please attach photocopies of Official Receipt, Certificate of Registration, Driver's License if the Insured is the one driving (<i>plasticized and renewal receipt of payment</i>)		Please attach a certification from the Airline/Shipping Company stating that insured was included in the list of passengers manifest.	

7. Was a police investigation conducted on the accident? If yes, please submit certified true copy of the police investigation report and copy (ies) of statement(s) of witness (es). If "No", explain why no such investigation was made.

8. Give the names and addresses of the physicians who attended to the Insured for injuries sustained from the accident:

Name of physician	Addresses of Hospital/Clinic	Date of attendance					
		From			To		
		Month	Day	Year	Month	Day	Year

9. Names, addresses and contact numbers of witnesses to the accident:

Name of witness	Addresses /Contact numbers

10. If confined in hospital, please provide:

Name of Hospital	Address	Date of confinement					
		From			To		
		Month	Day	Year	Month	Day	Year

11. Was there an autopsy or other post-mortem examination made on the body of the deceased?

12. If no autopsy was done, please explain why?

INFORMATION ON DECEASED INSURED'S PAST MEDICAL HISTORY
(Please answer each question, if not applicable, write N/A)

1. Give names and addresses of other physicians, if any, who had attended to the INSURED for other previous illnesses, diseases or injuries during the past two (2) years.								
			Dates					
			From			To		
			Month	Day	Year	Month	Day	Year

2. Names of DECEASED INSURED'S Family Physician	
Name of physician	Addresses /Contact numbers

B. Data Privacy Statement

I understand that as a financial institution, Insular Life is subject to existing and future government regulations. I therefore agree to be bound by all applicable domestic and international laws in relation to any matter including but not limited to anti-money laundering, tax monitoring and data privacy.

In this connection, I authorize Insular Life to process my personal and sensitive personal information (also known as personally identifiable information or PII) including the collection, usage, storage, retention, and disclosure of my PII in the related processes and systems until its disposal. I likewise give my consent to Insular Life to share such information to its subsidiaries, affiliates, agents, medical information sharing facility of the insurance industry and third parties for any legitimate purpose, including the underwriting and administration of insurance coverage and claims, marketing and promotion of products, market research, data analytics and automated processing systems, internal and external audits, and such activities for which my PII may be required in fulfillment of mandated services across my entire life stages.

I/We also confirm that I/we have sought the consent of the insured and/or the beneficiary/ies in sharing his/her personal and sensitive personal information, as may be applicable.

I hold Insular Life free and harmless from any liability that may arise from any collection, use, disclosure, destruction or sharing of said information.

C. Authorization

In relation to the claims application for the illness, injury and/or death of the Policy Owner or Insured under this Policy, I hereby authorize The Insular Life Assurance Co., Ltd. ("Company") or its authorized representative to secure any information and/or record belonging to the Policy Owner or Insured, as the case may be, under this Policy pertaining to the following:

1. Financial, employment/business/livelihood;
2. Health, both physical and mental;
3. Lifestyle;
4. Court (criminal, civil or administrative) records;
5. Personal; or
6. Other circumstances

from any of his/her employers, business partners, co-employees, staff, consultants, physicians, or from any hospital, clinic, health maintenance organization, diagnostic center, laboratory or any similar medical facility, any private or government agency or institution, organization, insurance industry association or from any individual person that may have knowledge, access to or custody of any such information or record.

I likewise authorize the foregoing individuals or entities that have/had knowledge, access to or custody of any of the abovementioned information or record to disclose and release the same to Insular Life or its representative and further hereby discharge them from any responsibility, obligation or liability arising out of or in connection with such disclosure and release of the information or record.

Done at _____ this _____ day of _____, 20 _____

 Name and Signature of Witness

 Name and Signature of Claimant

 Address of Witness

SUBSCRIBED AND SWORN to before me this _____ day of _____, 20 _____, by the above claimant who exhibited to me his/her government issued ID/Passport No. _____, issued at _____ on _____.

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

WARNING: It is unlawful (a) to present or cause to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and (b) to fraudulently prepare, make or subscribe any writing with intent to present or use the same, or to allow it to be presented in support of any claim. Such acts shall be punishable by a fine not exceeding twice the amount claimed or imprisonment of two (2) years, or both, at the discretion of the court. (Section 251, Insurance Code.)