The Insular Life Assurance Company, Ltd.
Insular Life Corporate Centre, Insular Life Drive
Filinvest Corporate City, Alabang, 1781 Muntinlupa City
E-mail: headofc@insular.com.ph I Website: www.insularlife.com.ph
Tel.: (632) 8-582-1818 I VAT REG. TIN 000-464-124-000

Insured's Statement Dread Disease Claim

To: The Insular Life Assurance Company, Ltd.

I hereby make claim under the policy or policies of this Company, numbered as follows _____.

A. Declaration:

All of the following answers and statements are true and 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. (a) Name _____ _____ _____ Given Name Surname Suffix
(b) Address
(c) Contact No/s.
(d) Date & Place of Birth
(e) Occupation
2. Date & Place of Commencement of Illness
3. Date first symptoms discovered
4. Give complete history of your illness. (Use reverse side if necessary) _____ _____
5. Give names of doctors, clinics, hospitals or other institutions where you received treatment and or confinement related to your Dread Disease Claim.

Date	Name of Doctors & Hospital	Treatment/ Diagnosis	Confinement (if any)

(NOTE: IN CASE YOU ARE IN POSESSION OF REPORTS FROM ANY DOCTOR OR HOSPITAL ABOUT TREATMENT RECEIVED IN CONNECTION WITH THE DREAD DISEASE SUFFERED, PLEASE LET US HAVE A COPY OF THIS REPORT.)

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, Ihereby 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 circumstance

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.

Signature of Insured:_____ Date: _____

Name and Signature of Witness:_____ Date: _____

SUBSCRIBED AND SWORN to before me this_____day of_____20___, by the above claimant who exhibited to me his/her Govt. issued ID/Passport No._____, issued at_____on_____.

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

NOTARY PUBLIC
My Commission expires on
_____

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.)