REQUIREMENTS FOR COCOLIFE/PHILPLANS CLAIMS

- CERTIFIED TRUE COPY OF DEATH CERTIFICATE (DECEASED) – 2 COPIES (ORIGINAL)
- BIRTH CERTIFICATE (DECEASED) – 2 COPIES (PHOTOCOPY)
- MARRIAGE CONTRACT – 2 COPIES (PHOTOCOPY)
- BIRTH CERTIFICATE (CHILDREN) – PHOTOCOPY
- VALID ID OF BENEFICIARY – 2 COPIES (PHOTOCOPY)
- VALID ID OF THE DECEASED MEMBER – 2 COPIES (PHOTOCOPY)
- PAYSLIP (ORIGINAL)
- PHOTOCOPY OF RECEIPT OF BURIAL/INTERMENT EXPENSES

COCOLIFE

CERTIFICATE OF CLAIMANT/S

Instructions:

This certificate must be accomplished by the beneficiary/ies of legal age to whom the insurance proceeds are payable. If the insurance proceeds are payable to minor/s, the certificate must be accomplished by his/her legal or judicial guardian, an official certificate of whose appointment and qualification must be submitted. If any beneficiary has died, a certified copy of the death certificate of such beneficiary must be submitted. Every question must be distinctly and fully answered.

A. GENERAL DATA OF DECEASED

1. Full Name (Please print) ____
   b. If deceased was a married woman, state maiden name __________________________
2. a. Date of birth _______________ b. Place of birth __________________________
   c. Source from which date of birth was obtained ______________________________
   (Family record or other record of certificate of birth should be referred to)
3. Residence at death ____
4. a. Date of death _______________ b. Cause of death __________________________
5. a. Occupation at date of death ____
   b. Date deceased last attended his usual work _________________________________

INSURANCE POLICIES OF DECEASED

Name of Company	Policy Number	Date Issued	Amount

B. HEALTH HISTORY OF DECEASED

1. Date deceased first complained or showed symptoms of last illness _______________
2. Date deceased first consulted a physician for his last illness _______________
3. Names and addresses of all physicians consulted by the deceased during the last three years and of, hospitals or other institutions where the deceased was confined or received treatment within the last three years:

Name of Physician/Hosp./Institution	Address	Date of Attendance/ Confinement From To	Illness/Condition

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CERTICATE OF AUTHORIZATION

This authorizes THE UNITED COCONUT PLANTERS LIFE ASSURANCE CORPORATION and/or is duly authorized representatives to secure whatever information or records are available from government and private hospitals and offices. This authorization is being made in connection with a claim on the insurance policy or policies issued by the insurance company on the life the deceased.

It is understood that any action you may take in connection with this authorization releases you or any and all members of your staff from any responsibility or obligation with the release of such records of information.

_____________________________	_____________________________
Witness (Please sign over Printed Name)	Beneficiary-Claimant (Please sign over Printed Name)

CLAIMS-008-0417-5

C. BENEFICIARY/IES – CLAIMANT/S

Are you electing one of the optional modes of settlement in lieu of an immediate cash payment? _________________ If so, which mode of settlement? _______________

(Not applicable if the claim does not involve a lump sum cash payment)

The undersigned hereby make/s claim to the insurance benefits of the deceased in the UNITED COCONUT PLANTERS LIFE ASSURANCE CORPORATION and agree/s that the written statements and affidavits of all the physicians who attended or treated the deceased and all other papers called for by instructions hereon, shall constitute, and they are hereby made a part of, these Proofs of Death, and further agree/s that the furnishing of this form, or of any other forms supplemental hereto, by said Company shall not constitute nor be considered an admission by it that there was any insurance in force on the life in question, nor a waiver of any of its rights to defense.

Full Name	Date of Birth	Relationship to deceased	Signature

Contact No. __________________ Date Accomplished ____________________

Basic Requirements:

The following documents should also be submitted:

1. Death Certificate
2. Policy Contract
3. Birth Certificate of Insured
4. Proof of Relationship of Beneficiary

The Company reserves the right to require or obtain further information should it deem necessary.

(Avoid expense: It is not necessary to employ the service of a person, firm or corporation regarding this claim. Write to: Claims Department, COCOLIFE Building, 6807 Ayala Ave., Makati City; or contact our provincial office nearest your residence. It is our duty to expedite action on this claim. We do not charge for this service.)

"Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim."

CERTIFICATE OF ATTENDING PHYSICIAN

MADE TO

COCOLIFE

(Before Making out this statement, read instructions at the back of this sheet.)

ALL QUESTIONS TO BE ANSWERED IN FULL

1. a. Deceased's name in full		b. Occupation: at death	Prior thereto
c. Residence at time of death	No. Street	City or Town	Province
2. a. Age of Deceased at death	b. Sex c. Height	d. Approximate weight in health	e. Color of hair

f. Were there any identification marks on the body? Yes__ No__ If yes, give particulars

3. How long had you known deceased?

4. a. Date of Death	b. Place of Death (If in hospital or institution, give name.)	c. Length of hospitalization

5. a. When were you first consulted for the condition which either directly or indirectly caused death?	Who consulted you? (Specify if deceased, relative or others	Date of last visit:

b. What was the immediate cause of death? (See instructions on reverse side.)

c. How long, in your opinion, did deceased suffer from this disease or impairment?

d. What were the contributory causes of death? Give below, the duration of each: (See instruction on reverse side)

Disease or Impairment	Duration

e. Was there any special connection (remote or proximate) between the death and the occupation, residence, habits or personal history of the deceased? ___ Yes ___ No If yes, state which and give particulars.

6. Give below particulars of each condition for which you treated or advised deceased prior to last illness:

Nature of Condition	Date	Duration	Result of treatment

7. Give names and addresses of other physicians and other practitioners who to your knowledge attended deceased during the past three years:

Name	Address	Disease or Impairment and Date

8. a. Was death due to suicide, homicide, or accident?

b. Was deceased under the influence of liquor or drugs when accident/suicide/homicide happened? Yes ___ No ___

9. Was there an official inquiry as to cause of death or a post mortem examination on the body of the deceased?
___ Yes ___ No If yes, which, by whom and with what result?

Dated at this day of ,20

Physician's Name in print		Physician's Signature
License No. (Privilege Tax)	Date	Physician's Address
Witnessed by		Witness Address

CLAIMS 048-0517-2

INSTRUCTIONS

ALL ANSWERS MUST BE ENTIRELY IN THE PHYSICIAN'S OWN HANDWRITING.

In the interest of accurate vital statistics, please conform to the International List of the causes of death when answering Question 5.

If an injury, describe the accident. If a suicide or homicide, state the means employed.

In surgical cases, state the nature of operation and the disease or condition requiring such procedure. In females, puerperal states are to be indicated. In neoplasm, give type part first involved. Please avoid indefinite terms. Describe any unusual features.

Where spaces provided for the answers are too small, such details as seen desirable should be given below.

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