MANILA BANKERS
LIFE AND GENERAL ASSURANCE CORP
The best way to show your Love

DISABILITY CLAIM FORM NO. 1

CERTIFICATE OF CLAIMANT

POLICY HOLDER _____ CLAIM NO. _____
MASTER POLICY NO. _____ POLICY/CERTIFICATE NO. _____

1. Full Name _____
2. Residence Address _____
3. Date of Birth _____ Place of Birth _____
4. Occupation _____
5. Is your policy assigned? YES( ) NO( ) If yes, give name(s) of assignee(s) _____
6. Give the date when you felt the first indications of failing health _____
   _____
7. What were the indications? _____
8. Give the date when you first received treatment for your present illness. _____
9. What was the treatment given? _____
10. Date of commencement of total disability _____
11. Give a complete history of your illness since becoming totally disabled.
    _____
    _____
    _____
12. Give name(s) of all physician(s) who attended you for your present illness.

NAME	DATE OF ATTENDANCE From	To

13. Give name(s) of hospital, sanitarium, or other institution where you received treatment.

NAME OF HOSPITAL	DATE OF CONFINEMENT From	To

14. Are you still confined to bed in hospital? YES( ) NO( ) If yes, give dates:
    From _____ To _____
15. Are you still confined to your home? YES( ) NO( ) If yes, give dates:
    From _____ To _____
16. If you are not confined to your home, why are you unable to work?
    _____
17. State briefly your present daily routine and mode of life.
    _____
18. Describe any improvement in your condition.
    _____