MANILA BANKERS
LIFE AND GENERAL ASSURANCE CORP

The best way to show your Love

CRITICAL ILLNESS CLAIM FORM NO. 1

CERTIFICATE OF CLAIMANT

POLICYHOLDER _____ CLAIM NO. _____

MASTER POLICY NO. _____ INSURANCE CERTIFICATE NO. _____

1. Full Name _____
2. Residence Address _____
3. Date of Birth _____ Place of Birth _____ Occupation _____
4. Give the date when you felt the first indication of failing health _____
5. What were the indications? _____
6. Date when you were informed of the diagnosis _____
7. Give the date when you first received treatment for your present illness _____
8. What was the treatment given? _____
9. Give a complete history of your illness since you were diagnosed of the illness.

   _____
10. Give name(s) of all physician(s) who attended you for your present illness.

NAME	DATE OF ATTENDANCE From	To
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

HOSPITAL	DATE OF CONFINEMENT From	To
_____	_____	_____
_____	_____	_____
_____	_____	_____

12. Are you now confined to bed in hospital? YES ( ) NO ( ) If yes, give dates:
    From _____ To _____
13. Are your parents or any sibling suffered or died from the same illness? YES ( ) NO ( )
14. Have you had any operation? YES ( ) NO ( ) If yes, give details (Surgical and Histological reports).

NATURE OF OPERATION	DATE
_____	_____
_____	_____
_____	_____

15. What illness(es) have you had prior to your present illness?

NATURE OF ILLNESS(ES)	DATE