MANILA BANKERS
LIFE AND GENERAL ASSURANCE CORP

The best way to show your Love

TERMINAL 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. Date when you were informed of the diagnosis _____
6. Name of the physician who made the diagnosis _____
7. What were the symptoms? _____

   _____
8. Give the date when you first received treatment for your present illness _____
9. What was the treatment given? _____
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

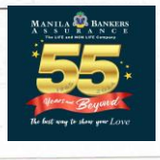
HOSPITAL	CONDITION	DATE OF CONFINEMENT From	To
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

12. Are you now confined to bed in hospital? YES ( ) NO ( ) If yes, give exact dates:
    From _____ To _____
13. Are you totally disabled? YES ( ) NO ( ) If YES, date total disability began _____
    (month/day/year)
14. Have you had any operation? YES ( ) NO ( ) If yes, give details.

NATURE OF OPERATION	DATE
_____	_____
_____	_____
_____	_____

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

NATURE OF ILLNESS(ES)	DATE
_____	_____
_____	_____
_____	_____



16. Name of doctor who has given you regular medical attendance for you illness _____

17. Name of other doctors not mentioned above who have treated you or been consulted by you. _____

_____

18. Have you ever received a pension from any government, or benefit from any life, accident or health company of benefit society or Workmen's Compensation? YES ( ) NO ( ) If yes, state when and from what source. _____

_____

I, the undersigned, do solemnly declare the foregoing answer and statements are full, complete and true, and further agree that the furnishing of this form, or any other forms supplemental thereto by the Company, shall not constitute an admission by it that there is any insurance in force in my life or a waiver of any of its rights or defense.

I HEREBY AUTHORIZE any physician or other person, or any hospital, sanitarium or other institution, to furnish the MANILA BANKERS LIFE INSURANCE CORPORATION any information that may be required concerning my illness. I agree that a photocopy of this authorization shall be considered as effective and valid as the original

DATE _____ _____

(month/day/year) **SIGNATURE OVER PRINTED NAME**