MANILA BANKERS
LIFE AND GENERAL ASSURANCE CORP

The best way to show your Love

ACCIDENT CLAIM FORM NO. 1

CERTIFICATE OF CLAIMANT

POLICYHOLDER _____ CLAIM NO._____

MASTER POLICY NUMBER _____ POLICY/CERTIFICATE NO. _____

INSTRUCTION:

This form is released to the claimant upon receipt of notice of an accident and its release is not an admission of claim. The Claim Forms must be submitted personally by the Insured where a medical examination shall be conducted by the MBLIC Medical Staff in order to insure a proper and equitable adjudication of the claim.

In the event that the Insured is totally incapacitated, which makes his appearance at the Home Office practically impossible, the forms may be submitted by the nearest relative or other responsible person in charge of the Insured during the disablement and who was responsible for the accomplishment of the form.

GENERAL DATA OF CLAIMANT

1. Full Name (Please print) _____
   If claimant is a married woman, state maiden name _____
   Date of Birth _____ Place of Birth_____
   Source from which the date of birth was obtained (Specify if birth/baptismal certificate of local civil registrar) _____
   Residence Address _____
   Business Address _____

2. Occupation at date of accident _____
   Name & Address of employer _____
   Date claimant last attended his usual occupation _____

DATA OF ACCIDENT

3. Date of Accident _____ Time_____A.M./P.M.
   Place _____
   How did it occur? _____
   Did the accident occur during the performance of the occupation? _____
   YES( ) NO( ) If yes, describe details: _____
   _____
   _____
   What was the nature of claimant's occupation immediately prior to the accident? _____
   _____

4. Describe in detail the nature and extent of the injuries. If arm, leg or eye, state whether RIGHT or LEFT. _____
   _____
   _____

QUESTIONS FOR VEHICULAR ACCIDENT ONLY

5. Were you a passenger in a public conveyance at the time of accident? YES ( ) NO ( ) If yes, state the type of conveyance and the plate number _____
   Was said conveyance then on a scheduled passenger service and on an established regular route? _____
   If yes, describe briefly _____
   _____

(Please attach a Police or Philippine Constabulary Investigation report relative thereto.)

6. Names and addresses of all physicians who attended you for the injuries sustained and period of treatment.

Name of Physician	Address	Inclusive Date of Attendance	Nature of Injuries

Who of the above-named physician/s has been in regular medical attendance during your confinement/treatment? _____

7. Names and addresses of hospital, clinic or other institution where you had been confined and received treatment (attach a certified true copy of clinical records of hospital).

Name of Hospital/ Institution	Address	Inclusive Date of Confinement	Nature of Injuries

8. Are you still confined by doctor's order? YES ( ) NO ( ) If yes, please check if confined to: ( ) hospital ( ) house

State the period you expect to be necessarily and entirely confined to hospital/house by doctor's order.

From _____ to _____

Did you perform or do you expect to perform any part of your business or work during the above period? YES ( ) NO ( )

If yes, state what _____

_____

9. If no longer confined to hospital/house but still receiving treatment, state the following:

a. What treatment you are receiving? _____

b. By whom _____ Where _____

10. Indicate your present condition as you understand it and describe the remaining effects, if any, from your accidental injury:

Please check: PRESENT CONDITION REMAINING EFFECTS

a. ( ) I am at present fully recovered _____

b. ( ) I am partially disabled (able to do some work) _____

c. ( ) I am totally disabled (unable to attend to any duties) _____

11. If you checked either question 10a or 10b, state:

a. When you returned to work (If an employee, please attach employer's confirmation letter). _____

b. Why you have not yet returned to work? _____

DECLARATION

I, the undersigned, do SOLEMNLY DECLARE that I am the person referred to in the foregoing particulars, that I have sustained the injuries before described by violent, accidental, external and visible means. I do further declare that I have always been uniformly sober and temperate in my habits, and that I was in no way under the influence of intoxicating liquor or drug when the accident occurred.

I DO HEREBY WARRANT THE TRUTH of the foregoing statements in every respect, and I agree that if I have made any false or fraudulent statements or any suppression, concealment, or untrue avernment whatsoever, or in any further declaration the Corporation may require of me with respect to the said accident, the Policy shall be voided as against the Corporation, and my right to compensation absolutely forfeited.

Dated at _____ this _____ day of _____

Witness' Name:

_____
Signature of Claimant

In Print _____
Signature _____
Occupation _____
Address _____

(If insured cannot sign this form, it should be signed by a near relative or any other responsible person in-charge of the Insured during his/her disability).

ACKNOWLEDGMENT

On this _____ day of _____ personally appeared before me the above named _____ with Community Tax Certificate No. _____ issued at _____ on _____ to me known to be the same person who executed the foregoing instrument and acknowledged to me that the answers to the above questions are full and true to the best of his/her knowledge, information and belief, and subscribed the same in my presence.

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

NOTARY PUBLIC
Until December 31, _____

Submitted by _____
Full Name Signature Relationship with insured

AUTHORIZATION

_____
Name of Institution or Physician

_____

_____
Address

Sir:

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

_____
Signature of Claimant