MANILA BANKERS LIFE AND GENERAL ASSURANCE CORP

The best way to show your Love

DEATH CLAIM FORM NO. 4

CERTIFICATE OF THE POLICYHOLDER

POLICYHOLDER
CERTIFICATE NUMBER: MASTER POLICY NUMBER:
(Before filling-up this certificate, read instructions at the back of this sheet. Every questions must be distinctly and fully answered)

GENERAL DATA OF DECEASED

1. a) Full Name of the Deceased (Please Print) _____

b) SSS/GSIS No. _____

c) If deceased was married woman, state maiden name _____

2. a) Date of Birth_____ b) Place of Birth _____

c) Source from which date of birth was obtained _____

(Birth Certificate, office record or record should be referred to) _____

3. Amount of Insurance _____ Address _____

4. a) Date of Death _____b) Place of Death _____

c) Cause of Death _____d) Age of Death _____

5. a) Occupation at date of death _____ b) Date Employed _____

c) Date on which deceased last worked full time _____

d) Employment status at time of death _____

e) Date employment was terminated _____

6. TO BE ANSWERED IF POLICYHOLDER IS AN ASSOCIATION, UNION, TRUSTEE, CLUB, ETC. _____

a) Date of membership of the deceased _____

b) Was deceased in good standing at time of death? ☐ Yes ☐ No

c) Date membership of deceased was terminated _____

HEALTH HISTORY OF DECEASED

1. Date deceased first complained or showed symptoms of last illness

2. Date deceased first consulted a physician for last illness

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

_____

b) Describe fully the particulars as to the place it occurred and how it occurred?_____

_____

_____

c) Was death due to occupational accident?_____If so, described briefly _____

_____

_____

4. Name and addresses of all physicians who attended deceased during the last illness and during the three preceding it and/or hospitals or other institution in which the deceased was confined or received treatment within the last three years.

Name of Physician/Hospital Institution	Address	Date of Attendance/Confinement From To	Disease or Condition

DATA OF BENEFICIARY – CLAIMANT		
NAME	RELATIONSHIP	ADDRESS

(If married minor or surviving spouse, please submit marriage contract)

1. Do you recommend payment of this claim? _____

_____

_____

2. Remarks_____

_____

Dated at _____this _____day of _____20_____

_____

Signature over Printed Name

_____

Position / Title

FORM NO. GCL06 (06-93)

I N S T R U C T I O N S

This Certificate should be fully completed and signed by the authorized Officer of the Group Policyholder. The answers to Question 6 convey additional information necessary on a Master Policy issued to an Association Union or for Trustee Plan.

If the Plan includes DEPENDENTS COVERAGE, this form may be used in reporting the death of a Dependent by answering Questions of General Data of Deceased, Health History of Deceased and Data of Beneficiary-Claimant as applicable to the Insured Employee/Member and by stating the word “Dependent” on the space provided for REMARK.