MANILA BANKERS LIFE INSURANCE CORPORATION

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

Cheers to 54 YEARS 1967 - 2021