

Death Claim Form

We understand that this claim is important to you. In order for us to speed up the process, please: (1) complete this form, (2) prepare the required documents; and, (3) submit the completed form and required documents to your agent or Philam Life Branch.

Being prepared might reduce some of the confusion and could help speed up the process. We want your claim experience to be a positive one.

To ease your claim procedures, use this checklist to identify the relevant documents required to be submitted.

Additional requirements may be required if the claim falls within the two-year contestability period of the policy.

MANDATORY REQUIREMENT/S

- Duly accomplished Death Claim Statement Form
- Original copy of NSO death certificate of the deceased. If death occurred abroad, death certificate must be authenticated by the Philippine embassy/consulate in the place of death
- One (1) valid identification card (with picture and signature) of the claimant/s

CONDITIONAL MANDATORY REQUIREMENT/S

- Marriage Contract – if spouse is the beneficiary
- Police Investigation Report – if death is caused by an accident
- Joint-Affidavit of Two Disinterested Persons – if there are discrepancies in the names of insured or beneficiaries
- Birth Certificate of minor beneficiary – if child is the beneficiary
- Guardianship bond or court order – if the share of minor beneficiary benefits exceeds PHP 500,000
- Affidavit of Legal Guardianship – if beneficiary is a minor
- Attending Physician Statement – for Contestable Claims
- Death Certificate of deceased beneficiary/ies
- Birth Certificate of insured – if parents are the beneficiary/ies

Warning: filing of fraudulent claim is penalized by law:

Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.

**HELPING PEOPLE LIVE
HEALTHIER, LONGER, BETTER LIVES**

Date: (mm/dd/yyyy) _____

Policy Number

--	--	--	--	--	--	--	--	--	--	--	--

Indicate policy numbers
where this claim may also be applicable

Certificate Number
(Applicable for Corp.Sol. only)

--	--	--	--	--	--	--	--	--	--	--	--

This form is to be filled by the claimant. Please do not sign on a blank form. No fees, commission or charges of whatever nature are payable to Agents or Employees of the Company in respect of this claim.

DECEASED'S INFORMATION:

Deceased's Name in Full: (Last Name, First Name, Middle Name)

Date of Birth: (mm/dd/yyyy)

Place of Birth:

CLAIMANT'S INFORMATION:

Claimant's Name in Full:

(Last Name, First Name, Middle Name)

Claimant's Maiden Name if married:

Date of Birth: (mm/dd/yyyy)

Relationship to the deceased:

Claimant's Address:

Mobile Number: (09XX - XXXXXXX) (Where we will send status and updates of your claim)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Email:

Send me Policy updates via:

Email

Mail

SMS Notification

Is agent on record (the agent appearing in the insurance application form) authorized to pick-up the check?

Yes

No

If yes, a duly written authorization is required, and only for the agent on record.

TIN:

Are you a US citizen? If yes, please submit a W-9 form

Yes

No

If place of birth is the US, please submit W-9.

If address is in the US, please submit W8 BEN.

If to be credited to a US bank account, please submit W8 BEN.

**Track your
Claim Status**

Once your claim is registered, you will be updated through SMS. If you have any query on your claim, please reach us at:



TALK TO US NOW

(02) 528-2000



EMAIL US

PHILAMLIFE@AIA.COM

Philam Life is committed to making your insurance claim process as easy and stress-free as possible. Thank you for insuring with us. We are always glad to be of service.

Philam Life Head Office
15-18th F Net Lima Bldg.
5th Avenue corner 26th St.
Bonifacio Global City,
Taguig, Metro Manila,
Philippines 1634

**HELPING PEOPLE LIVE
HEALTHIER, LONGER, BETTER LIVES**

PAYMENT INSTRUCTION: (all succeeding benefits will be credited to the indicated Bank Account)

Credit to my Bank Account
 (NOTE: If the account you specify is with a bank other than BPI or BDO, applicable charges may be deducted from the proceeds)

Bank:

Branch:

Type of Account: Savings Checking Account Currency: Dollar Peso

Account Name:

Account Number:

Claim at any BPI / BPI Family Branch
 (NOTE: In this option, you are authorizing the Company to use the mobile phone number stated above for communication pertaining to the transaction)

I certify that I am the owner/insured/beneficiary/assignee of the policy (ies) with Philam Life and that I am the account owner of the above designated bank account. I certify to the accuracy and truthfulness of the bank information which I provided and I am aware that any discrepancy may cause delay in the crediting of the proceeds to my account. In the event of changes to this information, I shall inform Philam Life in writing. Further, I agree that the crediting by Philam Life of the amount that may be due to me to the above bank account which I designated shall forever release and discharge Philam Life from all actions, claims, and demands relating to my claim against the policy (ies) with Philam Life.

Claimant's Signature

Date

Place

DECLARATIONS AND AUTHORIZATIONS:

1. I hereby certify that all information including all of my personally identifiable and sensitive information, which I have voluntarily provided to The Philippine American life and General Insurance Company, through this Form and related documents is true and correct to the best of my own knowledge and belief;
2. I further agree to third party processors required by the Company in order to maintain quality and deliver efficient and effective services relevant to my claim and other services I have availed of.
3. In compliance with the Data Privacy Act (DPA) of 2012, and its Implementing Rules and Regulations (IRR) effective since September 8, 2016, I allow the Philippine American Life and General Insurance Company (Philam Life) to provide me certain services declared in relation to the insurance claims I submitted. As such, I agree and authorize PhilamLife Company to;
 - a. Continue to use the policies' information to process insurance services and administer the benefit as stated in the policy(ies).
 - b. Retain the information for a period of 7 years from the date of termination of the policy, or at such time that I submit to Philam Life a written cancellation of this consent, whichever is earlier. I agree that my information will be deleted/destroyed after this period.
 - c. Retain my information in the Medical Information Database shared with other life insurance companies in accordance with the Insurance Regulation.
 - d. Share my information to affiliates and necessary third parties for any legitimate business purpose. I am assured that security systems are employed to protect my information.
 - e. Inform me of future campaigns and base its offer using the personal information I shared with the company. Kindly check (✓) appropriate box to indicate your consent;

 YES, I allow Philam Life and it's third party agents (ex. Financial Advisor) to use my personal information for future customer campaigns.

 NO, I do not allow Philam Life and it's third party agents (ex. Financial Advisor) to use my personal information for future customer campaigns.
4. I hereby acknowledge and warrant that I have acquired the consent of all parties pertinent to this transaction to disclose their information for the proper administration and provision of services requested from this transaction. I hereby hold free and harmless and undertake to indemnify the Company for any complaint, suit or damages and the like which any party may file or claim against the Company in relation to this Acknowledgement and warranty.
5. I hereby authorize Philam Life or any of its authorized representative to secure whatever information or records from any employer, physician, hospital or clinic, other medically related facility, and any organization or persons who have records and/or knowledge with regards to the illness, sickness or injury of the Insured as described in this Claim Statement Form. This authorization is in connection with my claim on the insurance policy (ies) issued by the Company on the life of the insured. I understand that failure to release such employment or medical records may delay the processing and/or deny my claim for insurance proceeds.

Claimant's Name in Full:
 (Last Name, First Name, Middle Name)

Claimant's Signature

Date

Place