NOTICE OF CLAIM FORM

EMPh Form – 2021–NOC–01 rev. 08-2021

NAME OF INSURED/DECEASED: _____ **Reference No.** _____

CHANNEL: _____ **Branch/Outlet:** _____

PRODUCT NAME: _____ **Principal Member/Insured:** _____

Name of Claimant/Beneficiary: _____ **Relationship to Insured/Deceased:** _____

Please check [v] the one that applies.

Relation of the Insured/Deceased to the Principal Member: [ ] Principal [ ] Spouse [ ] Child [ ] Parent [ ] Sibling

Claim Type: [ ] Basic Life [ ] Accidental Death [ ] Daily Accident Hospital Benefit [ ] Accidental Disablement/Dismemberment [ ] Property Assistance

REQUIRED if BASIC LIFE; to be completed by the Claimant

Date of Death: _____ Cause of Death: _____ Place of Death: _____

REQUIRED if Accidental Disablement/Dismemberment, Daily Accident Hospital Benefit or if claim is within contestability period. To be completed by the Attending Physician

Diagnosis & Concurrent Conditions: _____

Date this condition was first diagnosed: _____ Is above condition a direct result of trauma/accident? [ ] Yes [ ] No

Was patient under the influence of **[ ] alcohol or [ ] prohibited drug** when accident happened? [ ] Yes [ ] No

Date of confinement: From _____ to: _____ Date of out-patient treatment: From _____ to _____

State a brief history of this condition: _____

Surgical operation performed (if applicable): _____

Name of Hospital: _____ Address: _____

M.D. _____ _____ _____ _____

Physician's Signature over Printed Name | License Number | Date Signed | Contact Number

If this portion cannot be complied, Medical Certificate must be submitted as an attachment.

MEDICAL INFORMATION AUTHORIZATION: We HEREBY AUTHORIZE any hospital, physician or other person who has attended or examined the Insured, to disclose when request to do so by the Insurance Company or its representative any and all information, prescriptions or treatment, with respect to his/her illness or injury, medical history and copies of all medical or hospital records. A photocopy of this authorization shall be considered as effective and valid as the ORIGINAL.

M.D. _____ _____ _____ _____

Physician's Signature over Printed Name | Date Signed | Claimant's Signature over Printed Name | Date Signed

REQUIRED if VEHICULAR ACCIDENT; to be completed by the Investigating Officer

Summary of Incident: _____

Was the insured the driver? [ ] Yes [ ] No Driver's License #: _____ Expiration Date: _____

If yes, did he/she have a driver's license at the time of the accident? [ ] Yes [ ] No, Driving Restriction: _____ [ ] No

Was the Insured under the influence of [ ] alcohol or [ ] prohibited drug when accident happened? [ ] Yes [ ] No

I hereby certify to the best of my knowledge and belief that the information provided by me are true and correct.

_____ _____ _____

Signature over printed name of Investigating Officer | Date Signed | Contact Number

Please accomplish this form in addition to police report. Form should be certified by:
If vehicular accident: Investigating police officer; if other nature of accidents: Investigating police officer or Barangay Captain or Center Chief.

REQUIRED if PROPERTY ASSISTANCE; to be completed by the Claimant

Nature of Loss: [ ] Fire [ ] Flood [ ] Typhoon [ ] Earthquake

Estimated Damage to Property: Php _____ Ownership: [ ] Owner [ ] Tenant

Summary of Incident: _____

List of Damaged Items with Estimated Corresponding Amount:

_____ _____ _____

_____ _____ _____

I HEREBY CERTIFY that the above statements are true and correct to the best of my knowledge. I further allow TSKI and InsuranceKo to disclose the information that I have hereby provided to other relevant Parties for the processing and, if approved, for the payment of my claim.

I HEREBY CERTIFY that I have personally checked and validated the authenticity of this claim.

_____ _____ _____ _____

Signature over printed name of Claimant/Beneficiary | Date Signed | Signature over printed name of Branch/Outlet Manager or Channel's Authorized Representative | Date Signed

Contact Number: _____ Contact Number: _____

FAILURE TO COMPLETE THIS FORM MAY DEL AY PROCESSING/PAYMENT OF THE CL AIM. The Company makes no admission of liability or waiver of rights by furnishing this form.