COOPERATIVE INSURANCE SYSTEM OF THE PHILIPPINES
No. 80 Malakas Street,Pinyahan, Central District, Quezon City
Tel No.923-0739 / 436-2590 Fax No. 924-0471 Email Add: cispclaims@yahoo.com

CLAIMANT'S STATEMENT FORM

To: Cooperative Insurance System of the Philippines

I hereby claim for benefit under the policy/policies of this company, numbered as follows: _____. All the following answers and statements are true, complete and correct according to my personal knowledge and belief. I understand that the furnishing of this form and other claim forms by the company does not constitute an admission that there is any insurance inforce.

I. INSURED'S INFORMATION

1 (a) Full name of deceased (Given Name, Middle Name, Last Name)

(b) Birthdate and Birthplace of deceased:

(c) Residence of deceased:

(d) Occupation:

(e) Name of Employer and Address (if any)

2 (a) Date of Death:

(b) Place of Death:

(c) Cause of Death:

(d) Date and Place of Interment:

3 (a) Date the deceased first complain of last illness.

Give indications:

(b) Names and addresses of all physicians who attended the deceased:

(c) Names and contact numbers of all medical institution or hospitals where deceased was treated:

4 If deceased was insured with other companies, please list down.

Name of Company	Policy No.	Amount of insurance

II. BENEFICIARY/IES INFORMATION:

1 (a) Full of name of beneficiary (Given Name, Middle Name, Last Name)

(b) Date of Birth _____
(c) Address _____
(d) Contact Number _____

2 Please state your relationship to the deceased such as son, daughter, father, mother, etc.

3 Are you a designated beneficiary? If answer is NO, please state in what capacity are you filing this claim form:

4 If you are filing this claim in behalf of minor beneficiary/ies, please give their names and dates of birth and your relationship to them. *(State if you are father, mother, grandmother, stepfather, etc.)*

MINORS NAME	BIRTH DATE	YOUR RELATIONSHIP

5 As father/mother of said minor/s, have you not been disqualified by a court of law from exercising the right to administer the property of each minor/s?
YES _____ NO _____
If YES, for what reason?_____

6 Is/Are the same minor/s under your actual custody and support?
YES _____ NO _____
If YES, for what reason?_____

7 Are there other beneficiaries? YES _____ NO _____
If YES, who are they?

Name	Birthdate	Relation to the Insured

NAME AND SIGNATURE OF WITNESS

Address of Witness: _____
Contact # of Witness: _____

NAME AND SIGNATURE OF CLAIMANT

Signed at _____
This _____ day of _____20___

SUBSCRIBE AND SWORN to before me this _____day of _____20 ___by the above claimant who exhibit to me his/her Residence Certificate No. _____Issued at _____on _____.
DOC NO. _____
PAGE NO. _____
BOOK NO. _____
SERIES OF 20___ _____

NOTARY PUBLIC

/claimsform#3

CLAIMANT'S AUTHORIZATION

To Whom It May Concern:

This authorizes Cooperative Insurance System of the Philippines or its authorized representative to secure whatever information or record you may have regarding the deceased, _____, who has been treated or examined in your hospital/clinic, _____. This authorization is being made in connection with any claim on the insurance policy issued by said company on the file of the deceased.

This authorization discharges you or any authorized member of your staff from any responsibility or obligation in connection with the release of such record or information.

Signed at _____this _____day of _____20_____.

WITNESS

BENEFICIARY / CLAIMANT

WITNESS

BENEFICIARY / CLAIMANT

IMPORTANT REMINDER: Forms not filled up accordingly will be returned.

/claimsform#3