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

CLAIMS REQUEST FORM

REGION: ________________
NAME OF COOPERATIVE: ________________
NAME OF INSURED MEMBER: ________________
NAME OF BENEFICIARY: ________________
RELATIONSHIP TO THE INSURED: ________________

NATURE OF CLAIM ***(please check [✓]*** **:**

- [ ] **Death Claim**
- [ ] **Hospital Income Benefit**
- [ ] **Accidental Medical Reimbursement**
- [ ] **Accidental Dismemberment**
- [ ] **Total & Permanent Disability**

PLAN/S ENROLLED ***(please check [✓]*** **:**

- [ ] **LPPI**
- [ ] **GYRT**
- [ ] **G-BLISS**
- [ ] **PAI/ICARD**
- [ ] **SIP**
- [ ] **SII**
- [ ] **SPECIAL GYRT (Formerly MABS)**
- [ ] **Others:___________**

DOCUMENTS REQUIRED:

FOR DEATH CLAIM:

- [ ] **Certified True Copy of Certificate of Death** ***(originally stamped/signed as certified true copy)***
- [ ] **Attending Physician's Statement** ***(if attended by a physician)***
- [ ] **Police Report** ***(for Accidental Death, Murder & Assault and Suicide)***
- [ ] **Claimant's Statement** ***(Notarized)***
- [ ] **Certified True Copy of Loan Ledger** ***for LPPI with signature of authorized cooperative representative***
- [ ] **Insurance Certificate** ***(for LPPI and PAI- if available)***
- [ ] **Official Receipt or Billing Statement** ***(if available)***

FOR HOSPITAL INCOME BENEFIT:

- [ ] **Medical Certificate** ***(including date of confinement and final diagnosis)***
- [ ] **Statement of Account/Hospital Bill**
- [ ] **Original Official Receipts**

FOR ACCIDENTAL MEDICAL REIMBURSEMENT:

- [ ] **Medical Certificate** ***(including date of confinement and final diagnosis)***
- [ ] **Police Report**
- [ ] **Statement of Account/Hospital Bill**
- [ ] **Original Official Receipts**

FOR TOTAL AND PERMANENT DISABILITY AND DISMEMBERMENT:

- [ ] **Medical Certificate** ***(including date of confinement and final diagnosis)***
- [ ] **Police Report**
- [ ] **Statement of Account/Hospital Bill**
- [ ] **Original Official Receipts**

NOTE:
CISP may require other documents depending on the circumstances arising from the claim.

We certify that the above information are true and correct:

______________________________	______________________________
Signature Over Printed Name	***Signature Over Printed Name***
COOPERATIVE MANAGER	**BENEFICIARY**

I hereby certify that the submitted requirements are assessed and checked by the undersigned:

____
Signature Over Printed Name
General Agency Manager / Financial Advisor / CSA

IMPORTANT REMINDER: Forms not filled up accordingly will be returned.
/claimsform#1