Paramount Life & General Insurance Corporation
11th Floor, Sage House, 110 V.A. Rufino Street,
Legaspi Village, Makati City, 1229, Philippines
Telefax: 772-9264
Email: directmarketing@paramount.com.ph

Madaling Kausap.

CLAIMANT'S STATEMENT

1. Deceased's name in full _____
   Deceased's residence _____

2. Deceased's Date of Birth Place of Birth

3. Deceased's Date of Death Place of Death

4. Occupation at death & address of employer, if not self-employed

5. Cause of death

6. a. Date deceased first complained of or gave indication of his last illness _____
   b. Date deaceased first consulted a physician _____

7. Name of family physician _____
   Address of family physician _____

8. Name and addresses of all physicians who attended deceased and hospitals/institutions where he/she was confined or received treatment during his last illness and 3 years prior thereto.

Name of Physician/ Hospital	Address	Date of Attendance	Disease/ Condition

9. Particulars of insurance with AEGON Life and other companies.

Name of Company	Policy No.	Amount of Insurance

10. Your date of birth

11. a. In what capacity or by what title do you claim this insurance? a. _____
    b. Relationship to the deceased. b. _____

12. If a claim is on behalf of minor beneficiary/ies, please state date of birth, names and your relationship to each.
_____
_____

I am claiming payment of the insurance from Paramount Life & General Insurance Corporation as described in Statement 11 of this form and for that purpose attest that the foregoing answers are true and complete to the best of my knowledge and belief.

I understand by furnishing of this form and other supplemental forms, no admission of any insurance in force nor waiver of the Company's rights to defense will be construed.

Dated at _____ this _____ day of _____ ,20____.

_____	_____
Claimant (Signature over Printed Name)	Witness (Signature over Printed Name)
_____	_____
Address	Address
_____	_____
Tel. No./Mobile No.	Tel. No./Mobile No.