PARAMOUNT
LIFE & GENERAL
INSURANCE

14th Floor, Sage House, 110 V.A. Rufino St.,
Legaspi Village, Makati City, 1229 Philippines
Tel. No.: +(632) 8772 9200
Fax No.: +(632) 8772 9297
www.paramount.com.ph

DEATH CLAIM REQUIREMENTS

1. **Duly accomplished Claimants Statement Form**
2. **Original copy of NSO Death Certificate of the Insured**
   If death occurred abroad, death certificate must be authenticated by the Philippine embassy/consulate in the place of death.
3. **Valid photo and signature bearing IDs of Claimant/s**
4. **Marriage Contract**
   (If spouse is the beneficiary)
5. **Police Investigation Report**
   (If death is caused by an accident)
6. **Joint-Affidavit of Two Disinterested Persons**
   (If there are discrepancies in the names of insured or beneficiaries)
7. **Birth Certificate of Beneficiary**
   (If the child is the beneficiary)
8. **Guardianship Bond or Court Order**
   If the share of minor beneficiary benefits exceeds PHP 500,000.00
9. **Affidavit of Guardianship**
   If beneficiary is a minor
10. **Attending Physician's Statement**
    For Contestable Claims
11. **Death Certificate of Deceased Beneficiary/ies**
12. **Birth Certificate of Insured**
    If parents are the beneficiary/ies

Note: Additional requirements may be requested depending on the circumstance/cause of death and evaluation of our Claims Department

CLAIMANT'S STATEMENT

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.

Date:	Policy / Certificate Number/s:

DECEASED'S INFORMATION

Deceased's Name in Full: (Last Name, First Name, Middle Name)	
Date of Birth: (mm/dd/yyyy)	Place of Birth:
Date deceased first complained or showed symptoms of last illness?	What medicines/tests were prescribed?

Name and addresses of all physicians who attended the deceased for the injuries sustained or during his last illness & during the five years immediately preceding it and/or other institutions were the deceased was confined or received treatment within the last (5) years. Please include name and address of the deceased's personal or family physician?

Name of Physician and Hospital	Address	Date of Confinement	Illness/Disease

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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:	Mobile Number:	Email:
Claimant's Address:			

PAYMENT INSTRUCTION

☐ **Credit to my Bank Account**

Bank: _____ **Branch:** _____

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

Type of Account: ☐ Savings ☐ Checking **Account Currency:** ☐ Peso ☐ Dollar

Account Name : _____

Account Number : _____

I certify that I am the Owner/Insured/Beneficiary/Group Policyholder/Assignee under Policy Contract/Insurance Certificate Number _____ with **Paramount Life & General Insurance Corporation** and that I am the owner of the above elected Bank Account. I hereby certify to the veracity of the bank details provided and any discrepancy may cause a delay in the crediting of the claim proceeds to the account. Any changes in the bank information shall be made by written notification to Paramount Life.

I agree that the crediting by Paramount Life to my bank account herein designated of the amount that may be due to me representing the full and final settlement of the claim, I hereby release and quit any all further claims of the proceeds of the life insurance and the supplementary benefit against Paramount Life, its successors and assigns, its officers and employees. I further agree to protect and save harmless, PARAMOUNT LIFE AND GENERAL INSURANCE CORPORATION from any and all consequence of said action and warrant to defend forever, said action against any and all persons who may assert any right for said amount or file any adverse claim thereon, and to reimburse the Company, of whatever payment it may make or damages and expenses it may incur by reason of such action or in event a case is filed against them for collection of the amount.

_____ _____ _____

Claimant's Signature Over Printed Name | Date | Place

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DATA PRIVACY CONSENT STATEMENT

For the purpose of processing my insurance claim on the Insurance Certificate/Policy issued by Paramount Life & General Insurance Corporation (hereafter, "PLGIC"), I hereby consent to:

a. the communication or transmittal of my medical information, medical records, and/or medical history, regarding the illness or injury for which I have been treated, by any physician, clinic or hospital and its authorized personnel, or any other natural or juridical person, to PLGIC, its branches, officers, employees, or agents;
b. the communication or transmittal of my other sensitive personal information in relation to aforementioned illness or injury, by any physician, clinic or hospital and its authorized personnel, or any other natural or juridical person, to PLGIC, its branches, officers, employees, or agents;
c. the processing of the personal data stated above, whether manually or via electronic channels, including but not limited to the collection, usage, storage, recording, customer/client profiling, and disclosure to third parties by PLGIC, its branches, officers, employees, or agents; and
d. the processing of the personal data stated above whether manually or via electronic channels, including but not limited to the collection, usage, storage, recording and customer/client profiling, by authorized third parties by PLGIC, its Branches, office employees, or agents, and

I further consent that the medical information and/or records provided shall be retained by PLGIC for at least five (5) years or for a longer period if the same is required to be preserved for litigation or to comply with legal or regulatory requirement. I likewise consent to the correction, amendment, deletion and/or disposal by PLGIC and other persons above-mentioned of these information/records which may be inaccurate or incorrect. I attest that I have been made aware of and understood my rights as data subject and how these can be exercised, and that I was informed of the nature, extent and processing of the personal data I provided.

ANTI-FRAUD WARNING
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.

DISCLOSURE: In accordance with the Insurance Commission's Circular Letter No. 2016-54 your medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the Insurance Commission's website at www.insurance.gov.ph.

For inquiries or concerns relating to the privacy and security of your personal data or information submitted to Paramount Life & General Insurance Corporation (PLGIC), please contact:

The Data Protection Officer
15th Floor, Sage House Building, 110 V.A. Rufino Street, Legaspi Village, Makati City 1229
E-mail: dataprotectionofficer@paramount.com.ph
Tel No. : +632 8772 9267
Mobile No.: +639176764846

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

_____ _____ _____
Claimant's Signature Date Place