Allianz PNB
LIFE INSURANCE

Policy No. ☐☐☐ ☐☐☐ ☐☐☐

STATEMENT OF CLAIMANT FOR DEATH BENEFIT

Every question must be completely answered and this form must be signed by all beneficiaries/claimants. The Company reserves the right to require further information should it be deemed necessary. Please do not leave any blanks and write legibly.

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 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 present or use the same, or to allow it to be presented in support of any claim.

INFORMATION ON ALL CLAIMANTS

(Please use a separate sheet if necessary)

Name _____ Date of birth (mm/dd/yyyy) _____

Address _____

Contact nos. _____ Nationality _____

Name _____ Date of birth (mm/dd/yyyy) _____

Address _____

Contact nos. _____ Nationality _____

Name _____ Date of birth (mm/dd/yyyy) _____

Address _____

Contact nos. _____ Nationality _____

Name _____ Date of birth (mm/dd/yyyy) _____

Address _____

Contact nos. _____ Nationality _____

Name _____ Date of birth (mm/dd/yyyy) _____

Address _____

Contact nos. _____ Nationality _____

INFORMATION ON THE DECEASED

Full Name _____

Residence at the time of death _____

Occupation at the time of death _____

Date of birth _____ Place of birth _____

Date of death _____ Place of death _____

Please state the cause of death and other facts pertaining to the manner of death

_____

_____

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Place of Interment _____ Date of Interment _____

Name of Cemetery/Crematory _____

Address & Contact No. of Cemetery/Crematory _____

Date when the deceased first complained of his/her last illness _____

Date of first visit by the physician who attended to the deceased during the last illness _____

Details of any previous illness ever suffered by the deceased _____

_____

_____

Names, Hospital Affiliations and Contact nos. of physicians consulted by the deceased during the year prior to his/her death

_____

_____

_____

_____

_____

Did the insured use intoxicating liquors to excess (give details)? _____

_____

Was the insured a smoker? _____ If yes, how many packs a day did he/she consume? _____

OTHER INFORMATION

In what other companies and for what amounts was the deceased insured?

_____

_____

Are there any proceedings in the insolvency or suspension of payment to creditors now pending against the insured or any of the claimants?

_____

_____

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DECLARATIONS

I/We hereby warrant the truth of the foregoing particulars in every aspect, and agree that if I have made, or if I shall make any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited.

I/We understand that furnishing of this form and other claim forms by the Company does not constitute an admission that there is any insurance in force nor any liability under the Policy.

AUTHORIZATION

I/We hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person, government institution or private company or entity that has any record or knowledge, to give to Allianz PNB Life Insurance, Inc. or its representative, any information whatsoever with reference to health, hospitalization, consultation, advice, examination, treatment or ailment, birth, death, marriage, employment and education of the Insured. A photocopy of this authorization shall be as effective and valid as the original.

I hereby expressly authorize Allianz PNB Life Insurance, Inc. to obtain, collect, record, organize, store, update, modify, use, share, transfer, disclose and/or destroy ("process"), whether manually or via electronic channels, any and all information, including personal and sensitive information, about me, the life insured, and/or my policy/ies, to **1)** facilitate, monitor, and improve the quality of my policy/ies and such services availed of by me, through programs including but not limited to customer satisfaction surveys, offer of related products and services, and statistical, actuarial and risk analyses, and to **2)** comply with legal or regulatory obligations of Allianz PNB Life Insurance, Inc. under applicable local or foreign laws, rules and regulations relating to matters including but not limited to anti-money laundering and tax monitoring/review/reporting. I also expressly authorize Allianz PNB Life Insurance, Inc. to share, transfer and/or disclose the said information to any of its intermediaries, branches, subsidiaries, affiliates, service providers, partners and government agencies for the said purposes. I likewise promise to inform Allianz PNB Life Insurance, Inc. of any changes relating to my personal information.

Signed at _____ this _____ day of _____ 20 _____ .

_____ Printed Name & Signature of Claimant

_____ Printed Name & Signature of Claimant

_____ Printed Name & Signature of Claimant

_____ Printed Name & Signature of Claimant

On this _____ day of _____, 20_____ personally appeared before me the above named_____, who being by me duly sworn, deposed that the answers to the above questions are full and true, to the best of his/her knowledge, information and belief, and subscribed the same in my presence.

Affiant exhibited to me his/her Residence Certificate No._____ issued at _____ on _____.

NOTARY PUBLIC

Doc.No._____;
Page No._____;
Book No._____;
Series of _____.

THIS STATEMENT MUST BE MADE BEFORE A NOTARY PUBLIC OR OTHER OFFICER DULY AUTHORIZED TO ADMINISTER OATHS AND HIS OFFICIAL SEAL ATTACHED, OR IF HE HAS NO SEAL, AUTHORITY AND THE GENUINENESS OF HIS SIGNATURE MUST BE ATTESTED BY A MUNICIPAL JUDGE OR BY THE CLERK OF COURT OF RECORD.