MB Life
MANILA BANKERS LIFE

VGP Center, 6772 Ayala Avenue, Makati City

DEATH CLAIM FORM NO. 4

GROUP CLAIM SECTION

CLAIMS DEPARTMENT

CERTIFICATE OF THE POLICYHOLDER

POLICYHOLDER

CERTIFICATE NUMBER: MASTER POLICY NUMBER:

(Before filling-up this certificate, read instructions at the back of this sheet. Every questions must be distinctly and fully answered)

GENERAL DATA OF DECEASED

1. a) Full Name of the Deceased (Please Print) ____________________
   b) SSS/GSIS No. ____________________
   c) If deceased was married woman, state maiden name ____________________

2. a) Date of Birth____________________ b) Place of Birth ____________________
   c) Source from which date of birth was obtained ____________________
   (Birth Certificate, office record or record should be referred to) ____________________

3. Amount of Insurance ____________________ Address ____________________

4. a) Date of Death ____________________ b) Place of Death ____________________
   c) Cause of Death ____________________ d) Age of Death ____________________

5. a) Occupation at date of death ____________________ b) Date Employed ____________________
   c) Date on which deceased last worked full time ____________________
   d) Employment status at time of death ____________________
   e) Date employment was terminated ____________________

6. TO BE ANSWERED IF POLICYHOLDER IS AN ASSOCIATION, UNION, TRUSTEE, CLUB, ETC. ____________________
   a) Date of membership of the deceased ____________________
   b) Was deceased in good standing at time of death? ☐ Yes ☐ No
   c) Date membership of deceased was terminated ____________________

HEALTH HISTORY OF DECEASED

1. Date deceased first complained or showed symptoms of last illness

2. Date deceased first consulted a physician for last illness

3. a) Was death due to suicide, homicide or accident? ____________________
   b) Describe fully the particulars as to the place it occurred and how it occurred?____________________
   ____
   ____
   c) Was death due to occupational accident?____________________ If so, described briefly ____________________
   ____
   ____

4. Name and addresses of all physicians who attended deceased during the last illness and during the three preceding it and/or hospitals or other institution in which the deceased was confined or received treatment within the last three years.

Name of Physician/Hospital Institution	Address	Date of Attendance/Confinement From To	Disease or Condition

DATA OF BENEFICIARY – CLAIMANT		
NAME	RELATIONSHIP	ADDRESS

(If married minor or surviving spouse, please submit marriage contract)

1. Do you recommend payment of this claim? ____

____

____

2. Remarks____

____

Dated at __________________________ this ____________________________ day of ________________________ 20_____

____

Signature over Printed Name

____

Position / Title

FORM NO. GCL06 (06-93)

I N S T R U C T I O N S

This Certificate should be fully completed and signed by the authorized Officer of the Group Policyholder. The answers to Question 6 convey additional information necessary on a Master Policy issued to an Association Union or for Trustee Plan.

If the Plan includes DEPENDENTS COVERAGE, this form may be used in reporting the death of a Dependent by answering Questions of General Data of Deceased, Health History of Deceased and Data of Beneficiary-Claimant as applicable to the Insured Employee/Member and by stating the word “Dependent” on the space provided for REMARK.