



1 COOPERATIVE INSURANCE SYSTEM OF THE PHILIPPINES LIFE AND GENERAL INSURANCE

Email Add: claimslife@1cisp.coop

PHYSICIAN'S STATEMENT FOR DEATH CLAIMS

NAME OF DECEASED	
ADDRESS	
APPARENT AGE AT DEATH	
DATE OF DEATH	
PLACE OF DEATH	

1 What was the immediate cause of death? _____

2 What factors / disease contributed to the cause of death? _____

Duration of contributory causes? _____

3 What was the first indication of failing health? _____

When were they first noticed? _____

4 Were there any other disease/s suffered by the deceased? _____

If yes, kindly mark them from the choices below and indicate when were they diagnosed. If they are not found from the selection, you may place them on the space provided.

____ Hypertension Others: _____

____ Diabetes Mellitus _____

____ Heart Disease _____

____ Kidney Disease _____

Would you know if the deceased suffered from any congenital disease/s? YES NO

If yes, kindly specify _____

5 Was the deceased bedridden prior to his/her demise? YES NO

If Yes, since when? _____ If

No, was the deceased prevented from attending to his daily work activities prior to his demise? _____

6 When did you first attended the patient? _____

Date of FIRST attendance in last illness? _____

Date of LAST attendance in last illness? _____

7 Was there any evidence that would indicate that the deceased died of suicide or foul play such as murder? YES NO

If Yes, kindly specify? _____

8 Did you personally see the remains of the deceased? YES NO

If not, who did? _____

Complete Name, Address and Contact Number of the Informant:

9 Was there any autopsy done? If yes, state which, by whom and what were the findings?

I hereby certify to the best of my knowledge that the above statements are true and correct.

SIGNATURE OVER PRINTED NAME

FULL NAME OF ATTENDING PHYSICIAN	
LICENSE NO.	
SIGNATURE	
CLINIC ADDRESS AND CONTACT NUMBER/S	

IMPORTANT REMINDER: Forms not filled up accordingly will be returned.

1CISP values the trust and confidence you have bestowed upon us by choosing us to be your partner in securing your future. Thus, we strive hard to fully comply with existing laws and regulations such as:

- 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.
- In compliance with the Credit Information System Act, please be informed that should you have any insurance related transactions with us, 1CISP is mandated to share your basic credit data including related updates/corrections to the Credit Information Corporation (CIC) and other entities authorized under the law, even without your consent.
- In compliance with RA-10173 also known as the Philippine Data Privacy Act of 2012, whose implementing Rules and Regulations took effect on September 9, 2016 and its Implementing Rules and Regulations (IRR) effective since September 8, 2016, I allow 1 Cooperative Insurance System of the Philippines Life and General Insurance (1CISP) to provide me certain services declared in relation to the insurance policy/ies I purchased.

As such, I agree and authorize 1CISP to:

1. Continue to use my personal information to process insurance related transactions and administer the benefits as stated in the Group Insurance Contract.
2. Retain my personal information for a period of seven (7) years from the date of termination of my policy, or at such time that I submit to 1CISP a written cancellation of this consent, whichever is earlier. I agree that my information will be deleted/destroyed after this period.
3. Retain my health information in the Medical Information Database shared with other life insurance companies in accordance with the Insurance Regulation.
4. Share my personal information to affiliates and necessary third parties for any legitimate business purpose. I am assured that security systems are employed to protect my information.

I also acknowledge and warrant that I have acquired the consent from all parties relevant to this consent and hold free and harmless and indemnify 1CISP from any complaint, suit, or damages which any party may file or claim in relation to my consent.

Signed this ____ day of _____ 20__ at _____ City.

Signature over Printed Name of Beneficiary

Signature over Printed Name of Coop Authorize Representative

Should you have questions or concerns about this consent form, please call 924-0471; 923-0739 or email us at support@cisp.coop

For more information on how 1CISP protects its data, you may visit our Privacy Statement at www.cisp.coop or type this link to your browser: <http://www.cisp.coop>

CONSENT

Kindly check (/) appropriate box to indicate your consent.

- YES, I allow 1CISP and it's third party agents (ex. Financial Advisor) to use my personal information for future customer campaigns.
- NO, I do not allow 1CISP and it's third party agents (ex. Financial Advisor) to use my personal information for future customer campaigns.

Signature over Printed Name of Beneficiary