1 COOPERATIVE INSURANCE SYSTEM OF THE PHILIPPINES LIFE AND GENERAL INSURANCE

Email Add: claimslife@1cisp.coop

CLAIMS REQUEST FORM

REGION : _____

NAME OF COOPERATIVE : _____

NAME OF INSURED MEMBER : _____

NAME OF BENEFICIARY : _____

RELATIONSHIP TO THE INSURED: _____

NATURE OF CLAIM ***(please check)*****:**

☐ **Death Claim** ☐ **Hospital Income Benefit** ☐ **Accidental Medical Reimbursement** ☐ **Accidental Dismemberment** ☐ **Total & Permanent Disability** ☐ **Burial Benefit**

PLAN/S ENROLLED ***(please check)*****:**

☐ **LPPI** ☐ **GYRT** ☐ **Special GYRT (MABS)** ☐ **G-BLISS** ☐ **PAI / I-CARD** ☐ **SIP**

☐ **SII** ☐ **I-SAVE** ☐ **KOOPAMILYA** ☐ **OTHERS:** _____

DOCUMENTS REQUIRED:

FOR DEATH CLAIM:

☐ **Certified True Copy of Certificate of Death** ***(originally stamped/signed as certified true copy)***
☐ **Attending Physician's Statement** ***(if attended by a physician)***
☐ **Police Report** ***(for Accidental Death, Murder & Assault and Suicide)***
☐ **Notarized Claimant's Statement** ***(Notarization can be waived provided that a Proof of Relationship will be submitted such as "Birth Certificate" or "Marriage Certificate"***
☐ **Certified True Copy of Loan Ledger** ***for LPPI with signature of authorized cooperative representative***
☐ **Insurance Certificate** ***(for LPPI and PAI- if available)***
☐ **Official Receipt or Billing Statement** ***(if available)***

FOR HOSPITAL INCOME BENEFIT:

☐ **Medical Certificate** ***(including date of confinement and final diagnosis)***
☐ **Statement of Account/Hospital Bill**
☐ **Original Official Receipts**

FOR ACCIDENTAL MEDICAL REIMBURSEMENT:

☐ **Medical Certificate** ***(including date of confinement and final diagnosis)***
☐ **Police Report**
☐ **Statement of Account/Hospital Bill**
☐ **Original Official Receipts**

FOR TOTAL AND PERMANENT DISABILITY AND DISMEMBERMENT:

☐ **Medical Certificate** ***(including date of confinement and final diagnosis)***
☐ **Police Report**
☐ **Statement of Account/Hospital Bill**
☐ **Original Official Receipts**

ADDITIONAL REQUIREMENTS:

☐ _____
☐ _____
☐ _____
☐ _____

CONTACT DETAILS:

HOME ADDRESS: _____
_____
_____

E-MAIL ADDRESS: _____

CONTACT NUMBER: _____

NOTE:

1CISP may require other documents depending on the circumstances arising from the claim.

We certify that the above information is true and correct:

_____
Signature Over Printed Name
COOPERATIVE MANAGER

_____
Signature Over Printed Name
BENEFICIARY

I hereby certify that the submitted requirements are assessed and checked by the undersigned:

_____
Signature Over Printed Name
Agency Manager / Financial Advisor / CSA

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