COCOLIFE
COCOLIFE Building, 6807 Ayala Avenue Makati City 1226
MCC P.O. Box 1681 Tel. No. 812-9015 to 26 * Fax No. 812-9053

INSURED'S STATEMENT OF DISABILITY

1. (A) FULL NAME (B) ADDRESS (C) TEL. NO. (WHERE YOU CAN BE REACHED)	5. NAMES OF ALL PHYSICIANS CURRENTLY OR MOST RECENTLY TREATING YOU AND INCLUSIVE DATES (A) _____ (B) _____ (C) _____ (D) _____ (E) _____
2. (A) CAUSE OF DISABILITY ☐ RELATED TO YOUR EMPLOYMENT ☐ INJURY ☐ ILLNESS (B) DATE & PLACE OF COMMENCEMENT OF DISABILITY _____ _____	6. OCCUPATION (A) PRESENT (OR LAST) EMPLOYER : _____ POSITION HELD: _____ (B) WHEN WAS THE LAST DATE YOU WERE ABLE TO DO THIS WORK? _____
(C) IF THRU ACCIDENT, WAS IT REPORTED TO THE POLICE OR PC AUTHORITIES?_____ IF SO, PLEASE ATTACH POLICE INVESTIGATION REPORT.	7. (A) ARE YOU CONFINED TO BED AT HOME? _____ IF SO, SINCE WHEN? _____ _____
3. GIVE COMPLETE HISTORY OF YOUR ILLNESS OR HOW INJURY WAS SUSTAINED AND HOW IT PREVENTS YOU FROM PERFORMING YOUR USUAL JOB DUTIES. _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	(B) STATE BRIEFLY YOUR PRESENT ROUTINE OF LIFE _____ _____ _____
	(C) HAS THERE BEEN ANY IMPROVEMENT IN YOUR CONDITION? _____ IF SO, PLEASE DESCRIBE. _____
	8. HAVE YOU DONE ANY WORK SINCE YOU GAVE UP YOUR USUAL OCCUPATION?
	9. WHEN DO YOU EXPECT TO RETURN TO WORK?
4. GIVE NAMES OF CLINICS, HOSPITALS, SANITARIUM OR OTHER INSTITUTIONS WHERE YOU RECEIVED TREATMENT AND INDICATE DATE OF CONFINEMENT. (A) _____ _____ (B) _____ _____ (C) _____ _____	10. IF YOU ARE UNABLE TO PERFORM YOUR REGULAR DUTIES, COULD YOU DO LIGHT CLERICAL OR SHOPWORK, LIGHT HOUSEWORK, LIGHT OUTDOOR WORK, CHORES, ETC._____
	11. DO YOU HAVE ANY CLAIM BECAUSE OF YOUR ILLNESS OR INJURY AGAINST ANY PERSON OR COMPANY? GIVE NAMES AND THEIR ADDRESSES. _____ _____

PLEASE USE REVERSE SIDE FOR ADDITIONAL INFORMATION WHICH WOULD HELP US EVALUATE YOUR CLAIM.

SIGNED AT _____ **THIS** _____ **DAY OF** _____**, 20** _____**.**

_____ _____
WITNESS **INSURED**

_____
ADDRESS OF WITNESS

INSURED'S AUTHORIZATION

I HEREBY AUTHORIZE any physician or other person or any hospital, sanitarium or institution to furnish THE UNITED COCONUT PLANTERS LIFE ASSURANCE CORPORATION, any information that may be required concerning my illness or disability.

This authorization discharges you or any authorized member of your staff from any responsibility or obligation in connection with the release of such record or information.

Signed at _____ this _____ day of _____, 20 _____.

_____ _____
WITNESS **INSURED**

"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."