



CERTIFICATE OF CLAIMANT/S

Instructions:

This certificate must be accomplished by the beneficiary/ies of legal age to whom the insurance proceeds are payable. If the insurance proceeds are payable to minor/s, the certificate must be accomplished by his/her legal or judicial guardian, an official certificate of whose appointment and qualification must be submitted. If any beneficiary has died, a certified copy of the death certificate of such beneficiary must be submitted. Every question must be distinctly and fully answered.

A. GENERAL DATA OF DECEASED

- 1. Full Name (Please print) _____
 b. If deceased was a married woman, state maiden name _____
- 2. a. Date of birth _____ b. Place of birth _____
 c. Source from which date of birth was obtained _____
 (Family record or other record of certificate of birth should be referred to)
- 3. Residence at death _____
- 4. a. Date of death _____ b. Cause of death _____
- 5. a. Occupation at date of death _____
 b. Date deceased last attended his usual work _____

INSURANCE POLICIES OF DECEASED

Name of Company	Policy Number	Date Issued	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

B. HEALTH HISTORY OF DECEASED

- 1. Date deceased first complained or showed symptoms of last illness _____
- 2. Date deceased first consulted a physician for his last illness _____
- 3. Names and addresses of all physicians consulted by the deceased during the last three years and of, hospitals or other institutions where the deceased was confined or received treatment within the last three years:

Name of Physician/Hosp./Institution	Address	Date of Attendance/ Confinement		Illness/Condition
		From	To	
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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CERTIFICATE OF AUTHORIZATION

This authorizes THE UNITED COCONUT PLANTERS LIFE ASSURANCE CORPORATION and/or is duly authorized representatives to secure whatever information or records are available from government and private hospitals and offices. This authorization is being made in connection with a claim on the insurance policy or policies issued by the insurance company on the life the deceased.

It is understood that any action you may take in connection with this authorization releases you or any and all members of your staff from any responsibility or obligation with the release of such records of information.

Witness
(Please sign over Printed Name)

Beneficiary-Claimant
(Please sign over Printed Name)

C. BENEFICIARY/IES – CLAIMANT/S

Are you electing one of the optional modes of settlement in lieu of an immediate cash payment? _____ If so, which mode of settlement? _____
(Not applicable if the claim does not involve a lump sum cash payment)

The undersigned hereby make/s claim to the insurance benefits of the deceased in the UNITED COCONUT PLANTERS LIFE ASSURANCE CORPORATION and agree/s that the written statements and affidavits of all the physicians who attended or treated the deceased and all other papers called for by instructions hereon, shall constitute, and they are hereby made a part of, these Proofs of Death, and further agree/s that the furnishing of this form, or of any other forms supplemental hereto, by said Company shall not constitute nor be considered an admission by it that there was any insurance in force on the life in question, nor a waiver of any of its rights to defense.

Full Name	Date of Birth	Relationship to deceased	Signature
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Contact No. / E-mail address: _____ Date accomplished: _____

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If you are filing in behalf of minor beneficiary, _____
(Name of minor beneficiary/ies)

Claimant’s information and affirmation, who is not disqualified or incapacitated.

1. In what capacity are you filing this claim for? as Trustee as Guardian
2. Is the minor beneficiary under your actual custody and support? Yes No
3. State your relationship with the minor beneficiary/ies: _____
4. Contact information (Contact No. / E-mail address): _____

Name of Trustee or Guardian: _____ Signature: _____

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Basic Requirements:

The following documents should also be submitted:

1. Death Certificate
2. Policy Contract
3. Birth Certificate of Insured
4. Proof of Relationship of Beneficiary

The Company reserves the right to require or obtain further information should it deem necessary.

(Avoid expense: It is not necessary to employ the service of a person, firm or corporation regarding this claim. Write to: Claims Department, COCOLIFE Building, 6807 Ayala Ave., Makati City; or contact our provincial office nearest your residence. It is our duty to expedite action on this claim. We do not charge for this service.)

“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.”

DATA PRIVACY POLICY

Cocolife upholds an individual's data privacy rights and assures that all your personal information, sensitive personal information and privileged information (collectively, "Personal Data"), collected and to be collected, are processed in compliance to the Data Privacy Act of 2012 (RA No. 10173 and its implementing Rules and Regulations (IRR).

COCOLIFE collects uses and stores your personal data. Thus, we are using your information to: (1) Evaluate the amended items provided; (2) Prevent Money Laundering or Terrorism Financing activities; (3) Comply with reportorial and regulatory requirements of law; and (4) Perform other reasonable purposes as may be necessary to implement the terms and conditions of the contract. When you provide information other than yours, you certify that you obtained their consent to disclose and process the information of your parents, spouse, children, dependent or about another person like stockholders, officers or employees.

We may share your personal data only to the extent that is reasonable and necessary to our employees and officers handling your orders and request; our subsidiaries, affiliates, partners, joint venture & other related parties e.g. any third- party service providers performing financial, administrative, technical and other ancillary services like credit investigation, and; person or entity that we contractually entered with, that ensures the confidentiality standard we implement and adhere to the DPA.

Cocolife shall ensure that personal data under its custody are protected against any accidental or unlawful destruction, alteration, and unlawful disclosure. It implements appropriate security measures in storing collected personal data. Personal data will be safely destroyed through secure means, after the lapse of the retention period provided by law or as determined by Cocolife.

Kindly browse through our Privacy Policy Statement in our company website to know more about the importance of your rights under the DPA. You may also send in your concerns to: COCOLIFE Data Protection Officer at 8TH Floor COCOLIFE Building, 6807 Ayala Avenue, Makati City or e-mail address at dpo@cocolife.com.

FOREIGN ACCOUNT TAX COMPLIANCE ACT ("FATCA")

You acknowledge that you are a United States ("U.S.") Personⁱⁱⁱ under U.S. Laws

You acknowledge that you are NOT a U.S. Person under U.S. Law

But you have at least one of the following U.S. Indiciaⁱⁱⁱ

And you have no U.S. indicia

***** You agree to advise us as soon as possible of any change in the information that you provided to us. *****

ⁱ U.S. Person means a) U.S. citizen (including dual citizens); b) U.S. permanent resident (green card holders); c) Individual that have stayed for a substantial number of daysⁱ in the U.S. (ie. More than 31 days during the current year or a total of 183 days during the 3-year period that includes the current year and the 2 years immediately before that) d) U.S. corporations, partnerships, and trusts created under U.S. law; or e) Foreign (non-U.S. registered) entities that are substantially owned by a U.S. Person (more than 10% of the entity by vote or value)

ⁱ a) U.S. Place of Birth; b) U.S. mailing or residence address (including a U.S. post office box) c) U.S. telephone number; d) A standing instruction to transfer funds to an account maintained in the United States; e) A currently effective power of attorney or signatory authority granted to a person with a U.S. address; or f) An "in-care-of" or "hold mail" address that is your sole address.

CONSENT. By signing this form, I/We consent to the collection, processing, storage and use of the personal data that I/we have provided for the purpose of processing my/our insurance claim, and the performance of any other actions as may be necessary to implement the terms and conditions of the insurance policy as well as the applicable purposes described in COCOLIFE's Privacy Policy (<https://www.cocolife.com/about/privacy-policy/>).

Signature over Printed Name of Claimant

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