

1. The Form is to be accomplished by the Claimant in BLOCK LETTERS
2. Please do not sign on a blank form. Only one (1) copy of this form is needed for processing.
3. Please check the box to indicate your choice(s).
4. This form must be submitted with the original policy and a photocopy of insured and policyowner's identification document.
5. This application will no longer be effective as soon as Claimant receives the full amount of payment from PARAMOUNT LIFE & GENERAL INSURANCE CORPORATION

Claim Payment Request Form

<input type="checkbox"/> Death Benefit	<input type="checkbox"/> Hospitalization Benefit	<input type="checkbox"/> Monthly Allowance	Policy Number
<input type="checkbox"/> Terminal / Critical Illness Benefit	<input type="checkbox"/> Return of Premium / Refund	<input type="checkbox"/> Accidental Indemnity Benefit	

CLAIMANT'S PERSONAL INFORMATION

Claimant's Full Name (Last, First and Middle Name)		Date of Birth (MM/DD/YYYY)
Claimant's Maiden Name, If Married (Last, First and Middle Name)		Relationship to the Deceased (for death Claim)
Telephone No.	Mobile No.	Email Address

Address (Number, Street, Apartment/ Suite No., Barangay/ Town, Municipality/ City)

PAYMENT INSTRUCTION

Check Payment Credit to Bank Account

Bank's Name	Branch	Type of Account <input type="checkbox"/> Savings <input type="checkbox"/> Checking	Account Currency <input type="checkbox"/> Peso <input type="checkbox"/> Dollar
Account Name		Account Number	

DECLARATIONS AND AGREEMENT

For the purpose of processing my insurance claim on the Insurance Certificate/Policy issued by Paramount Life & General Insurance Corporation (hereafter, "PLGIC"), I hereby consent to:	YES	NO
a. the communication or transmittal of my medical information, medical records, and/or medical history, regarding the illness or injury for which I have been treated, by any physician, clinic or hospital and its authorized personnel, or any other natural or juridical person, to PLGIC, its branches, officers, employees, or agents;		
b. the communication or transmittal of my other sensitive personal information in relation to aforementioned illness or injury, by any physician, clinic or hospital and its authorized personnel, or any other natural or juridical person, to PLGIC, its branches, officers, employees, or agents;		
c. the processing of the personal data stated above, whether manually or via electronic channels, including but not limited to the collection, usage, storage, recording, customer/client profiling, and disclosure to third parties by PLGIC, its branches, officers, employees, or agents;		
d. that the medical information and/or records provided shall be retained by PLGIC for at least five (5) years or for a longer period if the same is required to be preserved for litigation or to comply with legal or regulatory requirement. I likewise consent to the correction, amendment, deletion and/or disposal by PLGIC and other persons above-mentioned of these information/records which may be inaccurate or incorrect. I attest that I have been made aware of and understood my rights as data subject and how these can be exercised, and that I was informed of the nature, extent and processing of the personal data I provided.		

I hereby certify to the veracity of the bank details provided and any discrepancy may cause a delay in the crediting of the claim proceeds to the account. Any changes in the bank information shall be made by written notification to PARAMOUNT LIFE & GENERAL INSURANCE CORPORATION.

I agree that the crediting by Paramount to my bank account herein designated of the amount that may be due to me representing the full and final settlement of the claim, I hereby release and quit any all further claims of the proceeds of the life insurance and the supplementary benefit against Paramount Life, its successors and assigns, its officers and employees. I further agree to protect and save harmless, PARAMOUNT LIFE & GENERAL INSURANCE CORPORATION from any and all consequence of said action and warrant to defend forever, said action against any and all persons who may assert any right for said amount or file any adverse claim thereon, and to reimburse the Company, of whatever payment it may make or damages and expenses it may incur by reason of such action or in event a case is filed against them for collection of the amount.

ANTI-FRAUD WARNING: 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.

DISCLOSURE: 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.

Claimant's Signature over Printed Name of Insured

Signature over Printed Name of Agent/ Witness

Date Signed
(MM/DD/YYYY)

Place Signed

For inquiries or concerns relating to the privacy and security of your personal data or information submitted to Paramount Life & General Insurance Corporation (PLGIC), please contact:

The Data Protection Officer

15th Floor, Sage House Building, 110 V.A. Rufino Street, Legaspi Village, Makati City 1229
E-mail: dataprotectionofficer@paramount.com.ph
Tel No.: +632 8772 9267
Mobile No.: +639176764846

A department of:

