ST. PETER
LIFE PLAN • CHAPELS

NOTE: Please write legibly. The Company reserves the right to require further information if necessary. For more than two (2) claimants, please fill out another form.

TYPE OF CLAIM:

- ☐ CASH ASSISTANCE / EXTENDED CASH ASSISTANCE BENEFIT
- ☐ WAIVER OF INSTALLMENT (Total and Permanent Disability)
- ☐ ACCIDENTAL DEATH BENEFIT
- ☐ ACCIDENTAL DISMEMBERMENT BENEFIT

STATEMENT OF CLAIMANT FORM

ST. PETER LIFE PLAN, INC
St. Peter Corporate Center. 999 EDSA, across SM Annex

To Whom It May Concern:

I/We have the honor to give statements and provide information in connection with the insurance benefit claims of _____ with ST. PETER LIFE PLAN, INC.

I/We hereby submit these statements and information to form part of the proof of death, disability, and claims of the Planholder under Life Plan No. _____.

1. PLANHOLDER INFORMATION a. Full Name	
b. Residence Address	
c. Occupation	
d. Date of Birth	
2. DETAILS OF DEATH OR DISABILITY a. Date of Death / Disability	
b. Cause of Death / Disability	
c. State any other facts regarding the manner of death/disability	
3. FOR WITHIN CONTESTABILITY PLANS (within one (1) year from effectivity date) a. Give details of any illness, other than the last one, ever suffered by the planholder	
b. If the planholder was hospitalized, please state the name and location of the hospital	
c. Date when planholder first complained of last illness	
d. Date of first consultation/hospitalization of the planholder	
e. Date of the last hospitalization of the planholder	
4. Full Name of Person who has been paying the installments of the Life Plan	
5. CLAIMANT/S INFORMATION	
a. Full Name	a. Full Name
b. Age	b. Age
c. Residence Address	c. Residence Address
d. Contact Number	d. Contact Number
e. Email Address	e. Email Address
f. Bank Account / GCash Account Number	f. Bank Account / GCash Account Number
g. Relationship to the Planholder	g. Relationship to the Planholder

By signing this Claim Form, I / We guarantee that all the statements and information made by me/us are true and complete and that I/we have not concealed nor misrepresented any material fact from St. Peter. I / We also authorize St. Peter or its authorized representative to obtain any information or records necessary from any physician, clinics, hospitals, pre-need plan, and insurance companies for claims evaluation. I/we also effectively consent to collecting, processing, and handling my / our personal and sensitive information by St. Peter Life Plan, Inc. and its authorized entities for claims processing and evaluation.

_____ _____

Full Name / Signature / Date *Full Name / Signature / Date*