PhilPlans
Think Ahead!

# ASSURED / EMPLOYER'S STATEMENT

1. **Plan Details**

   Plan Number: _____

   Plan Type: _____

   Name of Planholder / Participant: _____

   Date of Birth: _____

2. **Death Claim Details**

   Date of Death: _____

   Cause of death: _____

   Place of death: _____

   Age at death: _____

3. **Coverage Data**

   Amount of Insurance Coverage: _____

   Designated Beneficiary/ies: _____

   Relationship to the Planholder: _____

   Claim check is payable to: _____

My/Our signature indicates that I/we have reviewed and certified the correctness of all information stated in this form.

I/We hereby consent, without need of prior notification, to the manual or automated processing, storage and disclosure by PhilPlans First, Inc. ("PhilPlans"), and its authorized employees and representatives, within or without the Philippines, in accordance with the Data Privacy Act and its implementing rules and regulations, of all such personal and/or sensitive personal information in this form, and all included attachments, solely for all purposes relevant to the enforcement and maintenance of my/our plan contract, and for all purposes deemed fit by PhilPlans, which shall include issuance, implementation and handling insurance policies, direct marketing, profiling, risk assessment, underwriting and administration of insurance coverage and claims, data analytics and data sharing with PhilPlans.

I/We also agree that my/our contact details may be utilized by PhilPlans to provide relevant updates of my/our plan/s, as well as company and product developments. Said consent also extends likewise from those persons whose information I/we have provided, whose consent I/we have secured.

Lastly, I/we agree that PhilPlans may store the same for the duration of the contract and a reasonable time thereafter.

Dated this _____ day of_____ year_____ at _____, Philippines.

Certified by : _____ _____

Authorized Group Signatory — Position

*(Signature over Printed Name)*

*NOTE: If with special request regarding **check payee** of the insurance proceeds, a letter signed by the group authorized signatory and counter-signed by the designated beneficiary/ies must be attached to this form. The request must be in the company letterhead.*

Form No. CB-034 (07June2018)

6.1.2018