KofC Family ... Our Concern

KNIGHTS OF COLUMBUS FRATERNAL
ASSOCIATIONOF THE PHILIPPINES, INC.
Gen. Luna cor. Sta. Potenciana Sts., Intramuros, Manila
Tel No. (02) 8527-2223 local nos. 151 to 159 /Telefax No. (02) 8527-2241

HOSPITAL DAILY INCOME DEATH BENEFIT CLAIM FORM

NOTE: Every question must be fully answered. The company reserves the right to require further information should it be deemed necessary. Please write all answers legibly.

Part I. To be completed by the Insured / Claimant.

1. a. HDIB Certificate No. _____
   b. Effective Date _____
2. a. Name of Insured / patient _____
   c. Residence of deceased when BC was issued _____
   d. Residence of deceased at the time of death _____
   e. Upon what document did you base your answers to the preceding questions? (Family records, certificate of birth, certificate of baptism, etc.) _____

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2. a. Date of death _____
   b. Causes of death _____
   c. Place of death _____
   d. Occupation of deceased at the time of issuance of the certificate _____
   e. Occupation of deceased at the time of death _____

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3. Please state the physicians whom the deceased consulted during his lifetime and/or clinic/ hospital where the deceased was confined or treated:

Date Attended	Nature of Illness/ diagnosis	Name/Addresses of Attending Physicians, hospitals/clinics where treatment was done
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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4. a. Has the certificate ever been assigned? _____
   b. If so, to whom and when _____
   c. Are there any endorsement on the Certificate other than those made by the Company? _____
   If so, furnish us a verified or certified copy of the endorsement.

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5. a. In what capacity, or by what title do you make this claim? _____
   b. Are you legally entitled to received the entire amount payable on the Benefit Certificate? _____

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6. In what other company/ies and for what amount was deceased insured?

Name o f Company	Total Coverage
_____	_____
_____	_____
_____	_____

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7. Do you guarantee that all the statements and answers made by you in this questionnaire are true and that you have not concealed any material facts from the company? _____

_____ _____
Claimant (Print name & sign) Claimant (Print name & sign)
Community Tax No. /TIN: _____ Community Tax No. /TIN: _____
Issued on _____ Issued on_____
At _____ At _____

_____ _____
Claimant (Print name & sign) Claimant (Print name & sign)
Community Tax No. /TIN: _____ Community Tax No. /TIN: _____
Issued on _____ Issued on _____
At _____ At _____

_____ _____
_____
Claimant (Print name & sign) Claimant (Print name & sign)
Community Tax No. /TIN: _____ Community Tax No. /TIN: _____
Issued on _____ Issued on _____
At _____ At _____

HOSPITAL'S OR ATTENDING PHYSICIAN'S AUTHORITY

To Whom It May Concern:

This is to authorize you to disclose and furnish the Knights of Columbus Fraternal Association of the Philippines, Inc. through its representative, any and all clinical records of the herein named patient.

_____ _____
Name of Patient Claimant (Print name & sign)

_____ _____
Date Relationship of the Patient