YGC CORPORATE SERVICES, INC.

Dismemberment/ Total and Permanent Disability CLAIM FORM

General Information:

Policyholder/ Insured Name : _____ (*Last Name*) _____ (*First Name*) _____ (*Middle Name*)

Policy No.: ☐☐☐☐☐☐☐☐☐☐☐☐

Patient Details:

Full Name: _____

Complete Address: _____ Date of Birth: (MM/DD/YY) _____

Mobile: _____ Landline: _____ E-mail: _____

Hospital Details:

Date Admitted: _____ Date of Discharge: _____

Diagnosis at Time of Admission: _____ No. of days confined: _____

Total Amount of Claim: _____

Documents Required for Claim Assessment:

1) Completed **Claim Form**
2) Two (2) government-issued IDs with signature
3) Certified True Copy of Death Certificate
4) Medical Certificate (*if hospitalized)*
5) Complete Police Report (*if due to accident)*
6) Release & Subrogation Form (for online bank payment)

_____ _____

Signature over Printed Name of Policyholder/ Insured **Date**