EMPLOYER'S STATEMENT REGARDING TOTAL DISABILITY

Disability Claim Form No. 3A

Corporate Solutions

The information below should be furnished by the Employer or his duly authorized representative.

1. Full Name of Insured/Payor:
2. Name and business address of Insured's/Payor's employer:
3. Nature of business:
4. What was the exact nature of work performed by Insured/Payor prior to disability?
5. What was the Insured's/Payor's monthly wage or salary prior to disability?
6. When was Insured/Payor employed by you? (MM/DD/YYYY)
7. When was the Insured/Payor compelled to give up part of his duties? (MM/DD/YYYY)
8. Is Insured's/Payor's illness or injury the sole cause of his absence from duty? Yes ☐ No ☐ If No, pls. give particulars:
9. Has Insured/Payor been absent from work before because of any illness or injury? Yes ☐ No ☐ If Yes, pls. give particulars:
10. Is Insured's/Payor's working for you now? Yes ☐ No ☐ If Yes, when did he return to work? (MM/DD/YYYY) If No, when do you expect him to return to work? (MM/DD/YYYY)
11. Is Insured/Payor still in your employ? Yes ☐ No ☐ If No, why not?

Name of Witness (pls. print)

Signature of Witness

Date signed (mm/dd/yyyy)

Name of Employer's Authorized Representative (pls. print)

Signature of Insured/Payor/Guardian/Beneficiary

Official Designation

Date accomplished (mm/dd/yyyy)

N O T I C E

In furnishing this blank, the Company does not thereby admit that there is any policy in force in the Company covering the person claiming to be disabled; and the Company expressly reserves all its rights and defenses.

There is no need to employ any person to help collect any sums rightly due under the insurance policies of the Philippine American Life and General Insurance Company, nor need any one incur any expense for this purpose except to pay the customary charges or fees required to complete the several forms or statements set forth in the following instructions.

The statements are to be furnished without expense to the Company. The statements usually required are as follows:

STATEMENT NO. 3A: Employer's Statement: To be made by the Claimant's Employer. If the Claimant was employed by an association, company, corporation, etc. this statement should be made by an officer of such concern, preferably by the officer under whom the Claimant was employed.

Please answer every question distinctly and fully and write below any additional information or details which you think are pertinent.

ADDITIONAL INFORMATION OR DETAILS