

NOTICE OF CLAIM

Date

Gentlemen:

This is to inform you that _____, insured
with your office under LRPP/AP3/ADSS COC No. _____ :

- ☐ died on _____ due to _____
- ☐ has been totally and permanent disabled due to _____
- ☐ suffered dismemberment on _____ 20__ due to: _____
 - ☐ both hands or both feet or sight of both eyes
 - ☐ either hand or foot and sight of one eye
 - ☐ one hand and one foot
 - ☐ sight of one eye

Please advise us on the claim documents needed for the payment of his/her benefit.

Very truly yours,

(Relationship with the Deceased/Insured)