



PLAN BENEFIT CLAIMS FORM

(PLAN DETAILS)

- ☐ YEARLY CASH BENEFIT (YCB)
☐ MATURITY BENEFIT (MB)
☐ PLAN TERMINATION VALUE (PTV)
☐ GUARANTEED CASH BENEFIT (GCB)

DATE REQUESTED:

MATURITY DATE:

PLAN AGREEMENT NO:

☐ ELITE ☐ MABUHAY ☐ FUND PROVIDER

PURPOSE OF CLAIMS:

CHECK IF CLAIMANT IS:

☐ PLANHOLDER

☐ BENEFICIARY

☐ REPRESENTATIVE

(PLANHOLDERS DETAILS)

PLANHOLDER'S NAME:

BIRTHDATE:

BIRTHPLACE:

AGE:

GENDER:

PRESENT ADDRESS:

CONTACT NO:

EMAIL ADDRESS:

SOURCE OF INCOME: ☐ EMPLOYMENT (PRIVATE) ☐ EMPLOYMENT (GOVERNMENT) ☐ BUSINESS / INVESTMENT

☐ OTHER PLEASE SPECIFY THE SOURCE OF INCOME:

EMPLOYER / BUSINESS NAME:

ADDRESS OF EMPLOYER / BUSINESS NAME:

ARE YOU AN INCUMBENT OR FORMER ELECTED OR APPOINTED GOVERNMENT OFFICIALS?

☐ YES

☐ NO

IF YES, PLEASE SPECIFY THE POSITION

(CLAIMANTS DETAILS)

CLAIMANT'S NAME:

BIRTHDATE:

BIRTHPLACE:

AGE:

GENDER:

PRESENT ADDRESS:

CONTACT NO:

EMAIL ADDRESS:

SOURCE OF INCOME: ☐ EMPLOYMENT (PRIVATE) ☐ EMPLOYMENT (GOVERNMENT) ☐ BUSINESS / INVESTMENT

☐ OTHER PLEASE SPECIFY THE SOURCE OF INCOME:

EMPLOYER / BUSINESS NAME:

ADDRESS OF EMPLOYER / BUSINESS NAME:

ARE YOU AN INCUMBENT OR FORMER ELECTED OR APPOINTED GOVERNMENT OFFICIALS?

☐ YES

☐ NO

IF YES, PLEASE SPECIFY THE POSITION

(AGREEMENT CLAUSE)

1. I agree to supply the personal information, as provided above, for the purpose of processing my application for pension benefit claim. I understand that my personal information collected will be stored in Caritas Group of Companies owned buildings and Data Center in compliance with the applicable laws and assurance of the IC, AMLC and other government agency. I acknowledge that CARITAS FINANCIAL PLANS, INC. is committed to protect this information with state of the art technology and processes and does not share this information to any third party other than for the processing of the requested settlement. As Data Owner/Subject, I understand that I have the rights to access, to be informed, to object, to erasure or blocking, to rectify, to damages to data portability and right to file complaint.

2. In compliance with local and foreign regulatory requirements, you agree to inform CARITAS FINANCIAL PLAN, INC. (CFPI) within thirty (30) calendar days of the change in your circumstances, which makes any information on a document incorrect, and provide a new or updated identification document. Please note that any update or change of information shall also apply to all other existing CFPI policies/plans. You agree that we are required by law, regulation or otherwise, to provide any and/or all information, we may disclose such information to competent authority or its delegate involved in examining, processing, using, collecting, transferring, storing or disclosing the relevant information. To update your records on file, kindly submit a duly accomplished PERSONAL DETAILS UPDATING FORM (PDUf) to any CFPI branch nationwide or email to planservices@cfpi.com.ph a clear scanned copy to this filled-in form.

3. In consideration of this PTV/MB. I/We hereby release and surrender all rights, title, and interest in this policy and agree to indemnify and protect CARITAS FINANCIAL PLANS, INC. from all claims and demands under this policy and from all losses, costs, and expenses incident to defending itself against such claims and demands. The liability of CARITAS FINANCIAL PLANS, INC. which issued this contract is fixed and limited to such cash value and any credit and upon its payment, shall be completely discharged. It is expressly warranted that no other person, partnership or corporation has any interest whatsoever in said policy and that no insolvency or bankruptcy proceedings are pending for or against the undersigned.

4. By signing this form, I hereby authorize CARITAS FINANCIAL PLANS, INC. (CFPI) to withdraw the amount equal to the Total Maturity Benefit, Longevity Benefit, Yearly Cash Benefits, or Pre-Maturity Benefits of this plan from the Trust Fund.

Signature Over Printed Name

Date Signed

(SUBMITTED REQUIREMENTS)

FOR MATURITY & PRE TERMINATION VALUE

- ORIGINAL PENSION POLICY ☐
- ORIGINAL CERTIFICATE OF FULL PAYMENT ☐
- VALID ID'S OF PLANHOLDER ☐
- VALID ID'S OF CLAIMANT ☐
- VALID ID'S OF REPRESENTATIVE ☐
- DEATH CERTIFICATE OF PLANHOLDER (IF DECEASED) ☐

FOR YEARLY CASH BENEFIT

- PHOTOCOPY OF PENSION POLICY ☐
- PHOTOCOPY OF CERTIFICATE OF FULL PAYMENT ☐
- VALID ID'S OF PLANHOLDER ☐
- VALID ID'S OF CLAIMANT ☐
- VALID ID'S OF REPRESENTATIVE ☐
- DEATH CERTIFICATE OF PLANHOLDER (IF DECEASED) ☐

OTHER DOCUMENTS

- NOTARIZED WAIVER OF RIGHT ☐
- NOTARIZED AFFIDAVIT OF GUARDIANSHIP ☐
- NOTARIZED SPECIAL POWER OF ATTORNEY ☐
- NOTARIZED QUIT CLAIM ☐
- NOTARIZED AFFIDAVIT OF LOSS AND INDEMNITY AGREEMENT ☐

IMPORTANT REMINDER

- 1) Requirements must be complete before processing of claims
- 2) Furnish a copy of the Request for Plan Benefit Claims to claimant. Original copy of the form and attachment will be forwarded to Head Office c/o Claims Benefit Processing Unit
- 3) Request for reissuance of check that has become staled shall be subject to processing fee.
- 4) Check that will be issued is for deposit only.
- 5) All documents submitted must be validated by Branch Personnel.

(DELIVERY INSTRUCTIONS)

DOCUMENTS RECEIVED & VALIDATED BY:

DATE RECEIVED BY:

CHECK RELEASE/PICK UP TO:

☐ HEAD OFFICE

☐ CFPI BRANCH:

☐ CHSI BRANCH:

(HEAD OFFICE PERSONNEL USE ONLY)

CHECK RELEASE DATE:

TOTAL PENSION BENEFIT FOR CLAIM: PHP

RECEIVED BY:

JV NO:

JV DATE: