



CLAIM FORM

REQUIREMENTS

- PENSION PLAN AGREEMENT
- CERTIFICATE OF FULL PAYMENT
- TWO (2) VALID GOV'T-ISSUED IDs
 - With Three (3) Specimen Signature
- FOR OTHER DOCUMENT (See Other Page)

PLAN AGREEMENT DETAILS

DATE REQUESTED:

PLAN AGREEMENT No.:

PLAN TYPE: ELITE MABUHAY FUND PROVIDER PLAN VARIANT:

PURPOSE OF CLAIMS: ***FOR WINDING UP PROCEEDINGS (Filed After 16 September 2025)***

PLANHOLDER'S 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

CLAIMANT'S DETAILS

RELATION TO PLANHOLDER: SELF BENEFICIARY AUTHORIZED REPRESENTATIVE

For Beneficiary and Authorized Representative, please specify relationship:

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



BENEFIT CLAIM AGREEMENT CLAUSE

1. I agree to supply the personal information, as provided above, for the purpose of processing my application for my claim against CFPI. 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 Insurance Commission (IC), Anti-Money Laundering Council (AMLC) and other government agency. I acknowledge that CFPI is committed to protect this information 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, I agree to inform CFPI within thirty (30) calendar days of the change in my circumstances, which makes any information on a document incorrect, and provide a new or updated identification document. Any update or change of information shall also apply to all other existing CFPI policies/plans. I agree that CFPI is required by law, regulation or otherwise, to provide any and/or all information, CFPI may disclose such information to competent authority involved in examining, processing, using, collecting, transferring, storing or disclosing the relevant information. To update my records on file, I shall submit a duly accomplished PERSONAL DETAILS UPDATING FORM (PDU) or this CLAIM form to CFPI or email a clear scanned copy of either of the mentioned form to claimsbenefit@cfpi.com.ph.

3. In consideration of this Claim, I hereby release and surrender all rights, title, and interest in this policy and agree to indemnify and protect CFPI 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 CFPI which issued this contract is fixed under the law and relevant IC issuances considering the liquidation of the company, and upon payment of CFPI, 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.

Signature Over Printed Name

Date Signed

OTHER SUBMITTED DOCUMENTS

- NOTARIZED AFFIDAVIT OF LOSS AND INDEMNITY AGREEMENT**
 - *If Pension Plan Agreement and Certificate of Full Payment is Lost*
- DEATH CERTIFICATE**
 - *If Planholder is Dead*
- NOTARIZED WAIVER OF RIGHT**
 - *If Claimant-Heirs is More Than One (1)*
- NOTARIZED AFFIDAVIT OF GUARDIANSHIP**
 - *If Beneficiary/ies is a Minor*
- NOTARIZED SPECIAL POWER OF ATTORNEY**
 - *If Claimant is an Authorized Representative*
 - *Please specify relationship of Claimant to the Planholder or Beneficiary/ies*

IMPORTANT REMINDERS

- 1) All requirements must be submitted before processing of the claim.
- 2) All Planholders and/or Claimants are encouraged to update their contact information (cellphone, landline, e-mail, and physical address) to ensure that the company may reach them whenever needed.
- 3) All Claimants must completely submit ORIGINAL documentary requirements to CFPI prior to the release of any claim. In the meantime, only PHOTOCOPY/ies will be accepted.
- 4) Filing of claims pursuant to the Insurance Commission's Liquidation Order is until 16 September 2025 only. Claims filed after 16 September 2025 shall be BARRED from normal liquidation proceedings, BUT shall be reconsidered in CFPI's dissolution and winding up proceedings.

HEAD OFFICE PERSONNEL USE ONLY

DOCUMENTS RECEIVED BY:

DATE RECEIVED:

REMARKS: