



COOPERATIVE HEALTH MANAGEMENT FEDERATION

Unit 102 Malakas Suite, #88 Malakas St., Brgy. Pinyahan, Central District, Diliman, Quezon City
Tel. No. 02-89310387 / 02-82832321 Email: 1coophealth@chmf.coop

DEATH CLAIM FORM

(IMPORTANT: Kindly fill-up this form and attach the required documents)

Date Submitted: _____

PATIENT'S NAME:

(Surname) (First Name) (Middle Name) (Ext.)

POLICY NUMBER:

COOPERATIVE NAME:

CONTACT NUMBER:

EMAIL ADDRESS:

DEATH BENEFIT REQUIREMENTS CHECKLIST

(To be filled up by the COOP Representative or COOP Member)

Please check the box to the corresponding documents submitted.

NATURAL / ACCIDENTAL DEATH

- Original or Certified true copy of Death Certificate
- Photocopy of Birth Certificate of Member
- Cooperative Members Certificate
- Photocopy of Valid ID and Coop Health ID of member
- Record of Hospitalization (if died in the hospital)
- Physicians Statement (if died in the hospital)
- Incident Report / Police Report (if died due to accident)
- Autopsy Report (if required for accidental death)

REQUIREMENTS OF BENIFICIARY

- Notarized Claimants Form
- Photocopy of Birth Certificate
- Photocopy of two (2) Valid ID
- Affidavit if document submitted has a problem
- NBI / Barangay Clearance or Residence Certificate
- Marriage Certificate (if deceased member is married)
- Letter of Explanation for late claim of death benefit (beyond 30 days after death of member)

NOTE:

1. Members requesting for death claim are given **THIRTY (30) WORKING DAYS** from the date of death to complete **ALL** the requirements stated above.
2. Incomplete requirements will not be processed.

For inquiries, questions and concerns, you may contact the **Medical Department** thru Mobile: 0917-8048837 / Landline: 02-82832321 or thru email: claims@chmf.coop.

Submitted by:

Checked by:

Received by:

(Signature over printed name)

Beneficiary of Member

(Signature over printed name)

Cooperative In-charge

(Signature over printed name)

CHMF Staff