DIGIPLUS CLAIMS ASSESSMENT FORM

POLICY NUMBER: SU-G16-HO-25-0000053-00

CLAIMANT'S INFORMATION

Customer Account ID	Customer's Name
Contact No./Mobile No.	Email Address

DETAILS OF CLAIM

Actual Date of Incident Being Complained:

Complete Details of Complaint:

Amount of Claim:

Screenshots of Supporting Documents:

CLAIMANT'S DECLARATION

This is to certify that to the best of my knowledge, all the information provided in this Assessment Form is true, complete, and correct. I acknowledge that it may be necessary to verify the information submitted to support my claim.

By submitting this form, I hereby agree and consent PhilFirst Insurance, Co., Inc. to collect, use and process my personal information in accordance with the Data Privacy Act of 2012.

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Signature over Printed Name   **Date Signed**