CCT MUTUAL BENEFIT ASSOCIATION INC.

VISUAL VERIFICATION FORM

I. PERSONAL INFORMATION

Name: _____ Branch/Fellowship: _____
Birthdate: _____ Age: _____ Status: _____
Date of Membership to CCT: _____Date of Membership to Insurance Program: _____
Beneficiary/Claimant: _____

II. DEATH INFORMATION

Date Reported to the Branch: _____ Date of Death: _____
Membership Category: ( ) Principal ( ) Dependent
Nature of Death: ( ) Accident ( ) Natural
Cause of Death: _____ Location of Wake: _____
Name and Signature of Informant: _____ Relationship to the deceased: _____

III. VISUAL VERIFICATION

Date of Verification: _____ Location of Wake: _____
Date of Internment: _____ Place of Internment: _____
Verified Beneficiary's Identity: ( ) Yes ( ) No

IV. CERTIFICATION

This is to certify that the above information are true and correct.

_____
(Signature over printed name)
Family Member

_____
(Signature over printed name)
MBA Partner Coordinator

_____
Team Servant
Contact No.: _____

V. FOR CCT MBA USE ONLY

Insurance Coverage: ( ) Less Than One (1) Year ( ) 1 Year or More But Less Than 2 Years
( ) 2 Years or More But Less Than 3 Years ( ) 3 Years and Above

Approved by: _____
CCT MBA CLAIMS OFFICER

VI. ACTION TAKEN BY TEAM SERVANT

RECOMMENDED AMOUNT

Amount of 1st Release: _____ Date Released: _____
(as per approved by Support Office)
Amount of 2nd Release: _____ Date Released: _____
(for full payment)