Manulife China Bank
LIFE ASSURANCE CORPORATION
a joint venture between Manulife Philippines and China Banking Corporation

Dear Mr. / Ms. _____ :

We are sorry to learn of your illness/injury.

In order for us to process the claim, we require the following:

1. Hospital Income Benefit Form
2. Attending Physician's Statement
3. Billing Statement
4. All available laboratory and tests results (as specified on the Attending Physician's Statement)
5. Medical Abstract / Admitting History
6. Valid Identification Document

Upon receipt of **ALL** the above required documents, we will process your claim and inform you of the outcome as soon as possible.

If you need any assistance, please contact our Claims & Settlement Department at 884-5433 local 1146 or at 884-5427 / 884-5429.

Attached are the Hospital Income Benefit and Attending Physician's Statement forms.

Notes:

I. Please note that the fee for completing the Attending Physician's Statement shall be at the expense of the insured / policyowner.

II. If you are asking another party to handle the claim process on your behalf, an authorization letter is required.

III. Please continue to pay the premiums.

IV. All claim documents maybe submitted personally at our office or through your servicing agent or by post.

Very truly yours,

_____

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HOSPITAL INCOME BENEFIT FORM

Note:

1. The issue of this form or any other form(s) does not represent any admission of liability by Manulife Philippines.
2. This form should be completed by the Claimant. (Life insured or Policyowner as the case may be).

Policy Number/s

Claim Number

1. PERSONAL PARTICULARS OF POLICYHOLDER

Name: _____ Passport/ID No _____

Date of Birth _____ Age: _____ Sex: _____ Office Telephone No. _____

Address _____ Home Telephone No. _____

_____ Mobile No. _____

Present Occupation _____

2. PERSONAL PARTICULARS OF LIFE INSURED (If different from above)

Name: _____ Passport/ID No _____

Date of Birth _____ Age: _____ Sex: _____ Office Telephone No. _____

Address _____ Home Telephone No. _____

_____ Mobile No. _____

Present Occupation _____

3. DETAILS OF ILLNESS

a. Reason of your confinement _____

a. Describe in detail all symptoms and/or nature of your illness.

_____

_____

b. Date when you first experienced these symptoms. ____ / _____ / _____
dd mm yyyy

c. How long had you been having these symptoms before you consulted a doctor? _____

d. Date when you first consulted a doctor. _____ / _____ / _____
dd mm yyyy

e. What was the diagnosis? _____

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DECLARATION AND AUTHORIZATION

I declare that all answers given by me in this form are, to the best of my knowledge and belief, true and complete.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, entity or employer, having information available as to diagnosis, treatment, results and prognosis, with respect to my physical or mental examination or condition, to give to MANULIFE PHILIPPINES or its legal representative, any and all information, or any other information or record it may need.

This form pertains to all records containing medical or non-medical data including, but not limited to, mental and dental care, drug or alcohol use, prescribed drugs, information about communicable diseases, and any employment and insurance coverage information.

I also authorize MANULIFE PHILIPPINES to obtain an investigative report from its duly authorized inspection agency which will provide any applicable information concerning this claim for insurance benefits on the life of the insured.

I agree that a photographic copy of this Authorization shall be valid as the original.

This authorization discharges you or any authorized member of your staff from any responsibility or obligation in connection with the release of such record or information.

Dated at _____ this _____ 20 _____

_____ _____

Signature of Policyholder / Claimant **Signature of Witness / Agent**

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ATTENDING PHYSICIAN'S STATEMENT
HOSPITAL INCOME BENEFIT

Patient's Name

_____

Attending Physician's Name _____ **Address** _____

This section must be completed by a qualified and registered physician at the expense of the claimant.

The above name is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **HOSPITAL INCOME BENEFIT**. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

A. GENERAL INFORMATION

1. Are you the patient's usual medical doctor? ☐ Yes ☐ No

   If yes, over what period do your records extend to? Start date _____ / _____ / _____
   dd mm yyyy

   End date _____ / _____ / _____
   dd mm yyyy

2. When did the patient first consult you for this condition? _____ / _____ / _____
   dd mm yyyy

3. Please state symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started

What / Who is the source of this information? _____

4. In your opinion what were the likely durations of the patient's symptoms? Please provide reasons.

   _____

   _____

5. Did the patient consult any other doctors for these symptoms before she consulted you? ☐ Yes ☐ No
   If yes, please provide details below.

Name of Doctor	Name of Clinic/ Hospital and Address

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6. Please provide the details below when you were consulted.

Dates Attended	Complaints & Physical Examination Findings	Duration of Illness	Diagnosis	Describe Treatment/ Procedure

7. Please state name and address of hospital _____

_____

Date of Admission _____ Date Discharged _____ No. of Days _____

Complaint/s _____

_____

Was patient given care at the ICU? ☐ Yes ☐ No

If yes, please provide period covered/number of days(must be supported with hospital bill) _____

Final Diagnosis _____ Prognosis _____

In your opinion, when is the patient expected to return to his usual occupation or employment? _____

8. Results of Laboratory Examination (Please include copies of test results available)

_____

_____

9. Describe in detail if Surgical Procedure was performed and Pathology Result (Please include copies available)

_____

_____

_____

10. Assessment of the Insured's present condition (Please include sequelae/complications/results of treatment of the illness(es).

_____

_____

_____

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11 . Please report any other information that may have a bearing on the insured's claim.

_____

_____

I hereby certify that the above statements are true and complete to the best of my knowledge and belief.

Name of Attending Physician (Please print)	**Degree/Specialty**
Signature	**Date Signed**
PRC Number / PTR Number	**Telephone Number (s)**

To the Attending Physician : You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.