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. Major Disease / Critical Illness Claim Form
2. Attending Physician's Statement
3. Original Policy Contract
4. Copy of your Valid Identification Document or Passport
5. All available laboratory and tests results (as specified on the Attending Physician's Statement)
6. Medical Abstract / Admitting History

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.

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 until the claim is approved.

IV. No benefit will be payable for any Major Disease contracted by the Insured **within ninety (90) days** from the issue date of This Supplementary Contract or the approval date of its last reinstatement, whichever is later.

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

Very truly yours,

_____

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MAJOR DISEASE / CRITICAL ILLNESS CLAIM FORM

Policy No.

Note:
1. The issue of this form or any other form(s) does not represent any admission of liability by Manulife Philippines.

Claim No.

2. This form should be completed by the Claimant. (Life insured or Policyowner as the case may be).

. 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) Type of Female Benefit you are claiming for _____

b) Describe in detail nature of your claim/symptoms of your illness.

_____

c) Date when you first experienced these symptoms. _____ / _____ / _____
dd mm yyyy

d) How long had you been having these symptoms before you consulted a doctor? _____

e) Date when you first consulted a doctor: _____ / _____ / _____
dd mm yyyy

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f) How long had you been having these symptoms before you consulted a doctor? _____

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

h) What was the diagnosis?

_____

_____

g) Have you previously suffered from or received treatment for a similar or related illness? ☐ Yes ☐ No
if yes, please provide the details.

_____

_____

4. RECORD OF MEDICAL CONSULTATIONS

Please provide the names of the doctors you had consulted in relation to your illness(es) and the addresses of their respective hospitals / clinics.

Name of Doctor	Name / Address of Hospital / Clinic	Dates of First Consultation

Details of the names(s) and address(es) of the doctor(s) you see most of the time when you are sick.

Name of Doctor	Address	Telephone No. / Fax No.

5. GENERAL

Have any of your blood relatives suffered from a similar or related illness? ☐ Yes ☐ No
If "yes", please provide the following details.

Relationship of Relative	Nature of Illness	Date Illness First Diagnosed

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Do you smoke? ☐ Yes ☐ No

If "Yes", please provide the following information.

(i) How many cigarettes do you smoke per day? _____

(ii) For how long have you been smoking? _____

Do you consume alcohol?

If "Yes, please provide the following information. ☐ Yes ☐ No

(i) Type of alcohol _____

(ii) Quantity consumed per day _____

6. OTHER INSURANCE(S)

Are you claiming from any other insurance company in respect of this critical illness? ☐ Yes ☐ No

If "Yes", please provide the following information.

Name of Insurer	Policy No.	Policy Effective Date	Type of Plan	Sum Assured	Claim Amount	Claim Notified (Yes/No)

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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