Manulife

CLAIMANT'S STATEMENT (Death Claim)

The Manufacturers Life Insurance Co. (Phils.), Inc.
Head Office: 10th Floor NEX Tower, 6786 Ayala Avenue, Makati City, 1229 Philippines
Customer Care: (02) 884-7000
Domestic Toll-Free: 1-800-1-888-6268
Website: www.manulife.com.ph Email:phcustomercare@manulife.com

Policy Number/s

PLEASE PRINT CLEARLY. USE BLACK INK.

REQUIREMENTS

1. Claimant's Statement (Death Claim) Form
2. Valid photo-bearing Identification Document of Claimant/s
3. Certified True Copy of Death Certificate of the Deceased
4. Attending Physician's Statement
5. Certified True Copy of Marriage Certificate from Philippine Statistics Authority (if the designated beneficiary is the Spouse)
6. Certified True Copy of Birth Certificate of Beneficiaries (if the designated beneficiary is Minor)
7. Policy Contract or Affidavit of Loss of Policy Contract

NOTE: Additional requirements may be requested depending on the circumstance/cause of death and evaluation of our Claims Department.

GENERAL INFORMATION

Name of Policyowner (Last, First, MI)	Date of Birth (MM/DD/YYYY)	Country of Birth
Name of Life Insured, if different from Policyowner (Last, First, MI)	Date of Birth (MM/DD/YYYY)	Country of Birth

Contact No.	Mobile No.	Occupation	Nationality/Citizenship/s (indicate all)

Mailing Address (Number, Street, Apartment/Suite No., Barangay/Town, Municipality/City, State, Country, ZIP Code)

Address abroad, if applicable (Number, Street, Apartment/Suite No., Barangay/Town, Municipality/City, State, Country, ZIP Code)	Email Address

DECLARATIONS AND DETAILS OF CLAIM

Date of Death (MM/DD/YYYY)	Place of Death	Cause of Death

Place of Interment	Date of Interment (MM/DD/YYYY)	Give indications

State Deceased's insurance with other companies

Name of Company	Policy No.	Face Amount

In what capacity do you claim the insurance?
- ☐ Named Beneficiary
- ☐ Assignee
- ☐ Others _____

State your relationship to the Deceased

If you are filling this claim in behalf of minor beneficiary/ies, have you been disqualified by court of law from exercising the right to administer the property of such minor? ☐ Yes ☐ No

Are you 18 years old or over? ☐ Yes ☐ No

If not, give Date of Birth (MM/DD/YYYY)

Choose from the Settlement Options below for payment of benefits. Refer to reverse side for details of below options.

- ☐ Lump Sum
- ☐ Interest Payments
- ☐ Fixed Installments
- ☐ Leave on Deposit
- ☐ Fixed Period
- ☐ Life Annuity with Period Certain
- ☐ Others _____

NAMES AND ADDRESSES OF ALL PHYSICIANS WHO ATTENDED THE DECEASED

NAME	ADDRESS	DATE (MM/DD/YYYY)	REASON/TREATMENT

NAMES AND LOCATIONS OF ALL HOSPITALS/CLINICS WHERE THE DECEASED WAS TREATED

HOSPITAL/CLINIC	CITY/TOWN	DATE (MM/DD/YYYY)	DIAGNOSIS

SETTLEMENT OPTIONS

If the benefits/proceeds of the policy or policies are payable in a single sum, you can have us pay the whole or any portion of such proceeds with any of the following **Settlement Options:**

OPTION 1, Leave on Deposit: The proceeds will be left with us as a deposit to accumulate at interest subject to your withdrawal from time to time but not more frequently than monthly until all the proceeds with interest are exhausted.

OPTION 2, Interest Payments: You may withdraw the interest earned on the proceeds left with us from time to time but not more frequently than monthly. Interest left with us will be added to the principal and included in computing interest.

OPTION 3, Fixed Period: We will pay equal installments for a period you specify until the proceeds with interest are exhausted. The period during which the installments will be payable must not be less than one year and not more than 30 years.

OPTION 4, Fixed Installments: We will pay specified amount of installments until the proceeds with interest are exhausted.

OPTION 5, Life Annuity with Period Certain: We will pay equal installments, during your lifetime. If you die before we have paid installments for 10 or 20 years, we will pay installments for the remainder of that period as they fall due. You specify the certain period when choosing this option.

DECLARATION AND AUTHORIZATION

All the answers and statements herein are true, complete and correct according to my personal knowledge and belief. I understand that the furnishing of this claim form and other forms by the Company does not constitute an admission that there is any insurance in force nor any liability for payment of the benefits provided in the plan agreement.

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

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.

Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.

I am aware that Manulife collects and uses my personal and sensitive information to operate an insurance business. By signing this form and continuing to avail of the company's products and services, I agree that these information can be processed, shared, disclosed, transferred or used by the company including its entity shareholders, directors and employees, its affiliates, subsidiaries, any member of the Manulife Group of Companies, advisors, representatives, industry associations and databases, local and foreign authorities, external auditors, and its third party service providers (whether within or outside the Philippines) within the rules set by the Data Privacy Act of 2012, as may be amended from time to time, relevant regulations and the company's privacy policy available at www.manulife.com/Privacy-Policy to communicate with, serve and get feedback from customers on the Company's products and services; conduct data analytics, profiling and automate data processing; comply with any reportorial and regulatory requirements, legal and contractual obligations of the Company as a member company of the Manulife Financial Group to both local and foreign regulatory and tax authorities, supervisory or enforcement agencies, courts or quasi-judicial bodies; and for other reasonable purposes related to the services provided or improvement/upgrade in systems and business processes.

Dated at _____ this _____, 20 _____.

_____
Policyowner/Claimant Signature over Printed Name

_____
Financial Advisor/Witness Signature over Printed Name

_____
FA Code