

# Claimant's Statement (Death Claim)

Please Print Clearly. Use Black Ink.

## General Information

Policy Number/s	Name of Beneficiary (Last, First, MI)
Mobile No. of Claimant	Email Address

## Credit to Account Details

Bank:  BPI  BDO  China Bank  Union Bank  Others \_\_\_\_\_

Currency:  PHP  USD

Account No. \_\_\_\_\_ Account Name \_\_\_\_\_

- Please make sure that your bank account details are updated and accurate to avoid unnecessary delay in funds disbursement. Charges may apply for other banks.

## Declarations and Details of Claim

Name of Deceased Insured (Last, First, MI)	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			In what capacity do you claim the insurance? <input type="checkbox"/> Named Beneficiary <input type="checkbox"/> Trustee <input type="checkbox"/> Assignee of Minor <input type="checkbox"/> Others Beneficiary
Name of Company	Policy No.	Face Amount	
State your relationship to the Deceased			Are you 18 years old or over? <input type="checkbox"/> Yes <input type="checkbox"/> No
If you are filling this claim in behalf of minor beneficiary/ies, If yes, please sign an affidavit of paternity/ custody and submit other documents required by Claims Department. <input type="checkbox"/> Yes <input type="checkbox"/> 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  Fixed Installments  Fixed Period  Others \_\_\_\_\_  
 Interest Payments  Leave on Deposit  Life Annuity with Period Certain

Names and Addresses of All Physicians Who Attended to the Deceased

Name	Address	Date (mm/dd/yyyy)	Reason/treatment

Names and Locations of All Hospitals/Clinics Where the Deceased was Treated

Hospital/Clinic	Address	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.

## Requirements

- |   |   |   |
|---|---|---|
| 1. Claimant's Statement (Death Claim) Form  | 1. Attending Physician's Statement  | 7. Certified True Copy of Birth                                     |
| 2. Present original and submit photocopy of valid photo-bearing Identification Document of Claimant/s | 5. Certified True Copy of Marriage Certificate from Philippine Statistics Authority (if the designated beneficiary is the Spouse) | Certified of Beneficiaries (if the designated beneficiary is Minor) |
| 3. Certified True Copy of Death Certificate of the Deceased   |   |   |
| 4. Attending Physician's Statement  |   |   |

NOTES: (1) The issue of this form or any other form(s) does not represent any admission of liability by The Manufacturers Life Insurance Co. (Phils.), Inc. (2) This form should be completed by the Claimant. (3) The fee for completing the Attending Physician's Statement shall be at the expense of the Claimant. (4) If you are asking another party to handle the claim process on your behalf, an authorization letter is required. (5) Additional requirements may be requested depending on the circumstances/cause of death and evaluation of our Claims Department (6) All claim documents maybe submitted through your Financial Advisor or may be sent directly to any Manulife Branch nationwide. (7) If you need any assistance, please contact our Customer Care Hotline at (632) 8884 7000 or 1-800-1-888-6268 (Domestic Toll-Free).

## Declaration and Authorization

All the answers and statements herein are true, complete and correct according to my personal knowledge and based on available documents. 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 industry association database, consumer reporting agency, entity or 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 duly authorized representatives, 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.

Manulife collects and uses 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 the information I provided and any subsequent changes to it, with the consent of the data, subject, concern can be processed, shared, disclosed, transferred or used by the company, including its entity shareholders, directors and employees, its affiliates, subsidiaries, business partners, any member of the Manulife Financial Group (including those located overseas), advisors, representatives, industry associations and databases, local and foreign authorities having jurisdiction over companies within the Manulife Financial Group, external auditors/counsels, 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.ph/customer-privacy-policy](http://www.manulife.com.ph/customer-privacy-policy) for purposes of:

- underwriting and approving my application;
- administering, serving and reinsuring my policy;
- marketing (including marketing of products and services ordered by any member of the Manulife Group of Companies and those of our business partners), promoting, getting feedback on our products and services, and measuring client satisfaction;
- conducting data analytics and doing automated data processing;
- preventing money laundering or terrorist financing activities;
- complying with reportorial and regulatory requirements of both local and foreign regulatory authorities (including local and foreign tax authorities and stock exchanges) as well as other legal, regulatory or contractual obligations of any member within the Manulife Financial Group, relating to information sharing, tax reporting or otherwise;
- the Company's internal purposes such as governance, risk, actuarial, claims and underwriting management, and reporting; and for other reasonable purposes related to the services provided.

\_\_\_\_\_  
Claimant's Signature over Printed Name

\_\_\_\_\_  
Date Signed (mm/dd/yyyy)

\_\_\_\_\_  
Place Signed

\_\_\_\_\_  
Financial Advisor/Witness Signature over Printed Name

\_\_\_\_\_  
Financial Advisor Code

\_\_\_\_\_  
Date Signed  
(mm/dd/yyyy)

\_\_\_\_\_  
Place Signed

## For Manulife Use Only

Valid IDs: Type: \_\_\_\_\_ ID#: \_\_\_\_\_

Documents Presented: \_\_\_\_\_

Documents received and validated by: \_\_\_\_\_

\_\_\_\_\_  
Name of CSO

\_\_\_\_\_  
Branch

\_\_\_\_\_  
Date (mm/dd/yyyy)