Manulife

The Manufacturers Life Insurance Co. (Phils.), Inc.
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CLAIMANT'S STATEMENT (Group Disability Claim)

Policy Number/s

PLEASE PRINT CLEARLY. USE BLACK INK.

GENERAL INFORMATION

Name of Policyowner (Last, First, MI) | Date of Birth (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

Mailing Address (Number, Street, Apartment/Suite No., Barangay/Town, Municipality/City, State, Country, ZIP Code) | Age | Sex ☐ Male ☐ Female

Contact No. | Mobile No. | Email Address

Present Occupation | Passport / ID No.

Name of Life Insured, if different from above (Last, First, MI) | Date of Birth (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

Mailing Address (Number, Street, Apartment/Suite No., Barangay/Town, Municipality/City, State, Country, ZIP Code) | Age | Sex ☐ Male ☐ Female

Contact No. | Mobile No. | Email Address

Present Occupation | Passport / ID No.

DETAILS OF CLAIM

Name of Employer

Address of Employer

Regular occupation immediately prior to becoming disabled

Describe your duties fully

Give date on which you last worked at your present regular occupation: ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY)

☐ If you have returned to work, give date of return: ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY)

☐ If you have not returned to work, when do you expect to? ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY)

Have you filed a claim with any other insurance company, private and government agency? ☐ Yes ☐ No If yes, complete the following:

Name of Company	Issue Date (MM/DD/YYYY)	Nature of Claim
	☐☐/☐☐/☐☐☐☐	
	☐☐/☐☐/☐☐☐☐	
	☐☐/☐☐/☐☐☐☐	
	☐☐/☐☐/☐☐☐☐	

☐ **DISABILITY DUE TO ILLNESS**

Date of first symptoms noticed (MM/DD/YYYY)

Date of first consultation/treatment (MM/DD/YYYY)

Examination/Treatment

Diagnosis

Attending Physician

☐ **DISABILITY DUE TO ACCIDENT**

Date of accident (MM/DD/YYYY)

Place of accident

Describe the injuries in detail

When were you first treated by a physician for the disability described above? (MM/DD/YYYY)

If so, Name and Address of Physician

NAME

ADDRESS

Have you consulted any other doctor because of your present disability? ☐ Yes ☐ No If yes, give details below.

NAMES AND ADDRESSES OF ALL PHYSICIANS WHO ATTENDED THE CLAIMANT

NAME OF PHYSICIAN	CLINIC / HOSPITAL	DATE CONSULTED (MM/DD/YYYY)	REASON

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

Life Insured (if different from Policyowner) Signature over Printed Name