Manulife

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

CLAIMANT'S STATEMENT
(Health Benefit Claim)

Policy Number/s

PLEASE PRINT CLEARLY. USE BLACK INK.

1. **Claimant's Statement (Health Benefit) form**
2. **Attending Physician's Statement**
3. **Valid photo-bearing Identification Document of Claimant/s**
4. **Applicable Receipts including Billing and Statement of Account**
5. **Medical Abstract / Admitting History**
6. **All available laboratory and tests results** (as specified on the Attending Physician's Statement)

NOTES: ***(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 Policy Owner as the case may be).* ***(3)*** *The fee for completing the Attending Physician's Statement shall be at the expense of the insured/policyowner.* ***(4)*** *If you are asking another party to handle the claim process on your behalf, an authorization letter is required.* ***(5)*** *Continue to pay the premiums until the claim is approved.* ***(6)*** *All claim documents maybe submitted through your Financial Advisor or may be sent directly to any Manulife Office nationwide.* ***(7)*** *If you need any assistance, please contact our Customer Care Hotline at (02) 884-7000 or 1-800-1-888-6268 (Domestic Toll-Free).*

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 | 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 | Passport / ID No.

DETAILS OF CLAIM

Type of Major Disease/Critical Illness you are claiming for | Describe in detail nature of your claim/symptoms of your illness | Date when you first experienced these symptoms (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

How long had you been having these symptoms before you consulted a doctor? | Date when you first consulted a doctor ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY) | What was the diagnosis?

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

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 (MM/DD/YYYY)
		☐☐/☐☐/☐☐☐☐
		☐☐/☐☐/☐☐☐☐
		☐☐/☐☐/☐☐☐☐

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.

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

RELATIONSHIP OF RELATIVE	NATURE OF ILLNESS	DATES ILLNESS FIRST DIAGNOSED (MM/DD/YYYY)
		☐☐/☐☐/☐☐☐☐
		☐☐/☐☐/☐☐☐☐
		☐☐/☐☐/☐☐☐☐

Do you smoke?
☐ Yes ☐ No

If yes, please provide the following information:
a) How many cigarettes do you smoke per day? _____ b) For how long have you been smoking? _____

Do you consume alcohol?
☐ Yes ☐ No

If yes, please provide the following information:
a) Type of alcohol: _____ b) Quantity consumed per day: _____

DECLARATIONS 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.

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

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ATTENDING PHYSICIAN'S STATEMENT (Health Benefit)

CLAIMANT'S NAME (Last, First, MI)	
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 **HEALTH BENEFIT.** To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

GENERAL INFORMATION

Are you the claimant's usual medical doctor? ☐ Yes ☐ No

If yes, over what period do your records extend to?
Start Date (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐ End Date (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

When did the claimant first consult you for this condition? (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

Please state symptoms presented and date symptoms first appeared.

SYMPTOMS PRESENTED AT FIRST CONSULTATION	DATE SYMPTOMS FIRST STARTED (MM/DD/YYYY)
	☐☐/☐☐/☐☐☐☐
	☐☐/☐☐/☐☐☐☐
	☐☐/☐☐/☐☐☐☐

What / Who is the source of this information? _____

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

_____

_____

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

NAME OF DOCTOR	NAME / ADDRESS OF HOSPITAL / CLINIC

Please provide the details below when he/she consulted you.

DATES ATTENDED	COMPLAINTS & PHYSICAL EXAMINATION FINDINGS	DURATION OF ILLNESS	DIAGNOSIS	DESCRIBE TREATMENT/ PROCEDURE

Was the service of an ambulance used for the claimant's hospital confinement? ☐ Yes ☐ No If yes, this must be supported by an official receipt for use of an ambulance.

Was the claimant admitted in the hospital? ☐ Yes ☐ No	If yes, please state name and address of hospital

Complaint(s)	Date of Admission (MM/DD/YYYY) / / Time Admitted _____	Date of Discharge (MM/DD/YYYY) / / Time Discharged _____

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

If yes, please state dates of ICU confinement (must be supported with a hospital billing statement): From _____ to _____ No. of days _____

Final Diagnosis	Prognosis

Were there prescription drugs during the claimant's hospital confinement? ☐ Yes ☐ No

If yes, this must be supported with the details/copy of drugs prescribed in the hospital billing statement.

Is there any Surgical Procedure Performed? ☐ Yes ☐ No

If yes, please describe the Surgical procedure performed in details including Pathology Result and copy of Operation Room Record.

_____

_____

Please state Name of Surgeon _____ Date of Surgery Performed (MM/DD/YYYY) / /

Was treatment as an outpatient required for the following?

Kidney Dialysis	☐ Yes	☐ No	If yes, please provide details/manner of treatment.
Stroke Treatment	☐ Yes	☐ No	
Cancer Treatment	☐ Yes	☐ No	

To the best of my knowledge, do you consider him/her to be **TOTALLY DISABLED** (unable to work)? ☐ Yes ☐ No

If yes, please provide period of Total Disability From / / (MM/DD/YYYY) To / / (MM/DD/YYYY)

Or give approximate date when he/she would be able to return to work (MM/DD/YYYY) / / (MM/DD/YYYY)

Please provide any other information that have a bearing to this claim.

_____

_____

_____

ATTENDING PHYSICIAN'S CERTIFICATION AND SIGNATURE

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	**Contact Number(s)**

To the Attending Physician: You may use additional sheets if more space is needed for the above information requested. You may also submit this form directly to any Manulife Office nationwide.