

CLAIMANT'S STATEMENT (Living Needs Benefit)

Policy Number/s

PLEASE PRINT CLEARLY. USE BLACK INK.

REQUIREMENTS

1. Claimant's Statement (Living Needs Benefit) form
2. Valid photo-bearing Identification Document of Claimant/s
3. Medical Abstract / Admitting History
4. Attending Physician's Statement
5. 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) | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Mailing Address (Number, Street, Apartment/Suite No., Barangay/Town, Municipality/City, State, Country, ZIP Code) | | | | | | Age | Sex <input type="checkbox"/> Male <input type="checkbox"/> 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) | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Mailing Address (Number, Street, Apartment/Suite No., Barangay/Town, Municipality/City, State, Country, ZIP Code) | | | | | | Age | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Contact No. | Mobile No. | Email Address | | | | | |
| Present Occupation | | Passport / ID No. | | | | | |

POLICY INFORMATION AND BENEFIT AMOUNT

Kindly state the list of policies with Living Needs Benefit Rider attached:

| | | |
|--|--|--|
| | | |
| | | |
| | | |

Benefit amount you are requesting: Total amount available (shall not exceed the maximum benefit amount indicated in the policy contract). A portion of benefit amount available
 PHP _____

DETAILS OF ILLNESS

Describe in detail nature of your claim/symptoms of your illness

| | | |
|--|--|--|
| Date when you first experienced these symptoms (MM/DD/YYYY) <input type="text"/> | How long had you been having these symptoms before you consulted a doctor? | Date when you first consulted a doctor (MM/DD/YYYY) <input type="text"/> |
|--|--|--|

What was the diagnosis?

CONFORMITY

By signing this form, I certify the information I have provided is true and complete.

I understand that any amounts I receive under this application represent advance payments of my Policy Proceeds and are not intended to allow third parties to cause me to involuntarily invade the Policy Proceeds ultimately payable to the named beneficiary/ies.

I certify that I am applying on a strictly voluntary basis and that I am not under any pressure of any kind whatsoever from any third party, any creditor, governmental agency, trustee in bankruptcy, or as a result of a court order.

Dated at _____ this _____, 20 _____.

Policyowner/Claimant Signature over Printed Name

Financial Advisor/Witness Signature over Printed Name

FA Code

I agree to the benefit amount requested:

Policyowner Signature over Printed Name

The irrevocable beneficiary understands that, if this request for benefits is paid, the face value of the policy(ies) listed above will be reduced or cancelled, depending on the amount of benefit requested.

Irrevocable Beneficiary Signature over Printed Name

Irrevocable Beneficiary Signature over Printed Name

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