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
(Total and Permanent Disability Claim)

Policy Number/s

PLEASE READ FIRST INSTRUCTIONS AND REMINDERS AT LAST PART. PLEASE PRINT CLEARLY. USE BLACK INK.

REQUIREMENTS

1. **Claimant's Statement (Total and Permanent Disability Claim) form**
2. **Attending Physician's Statement**
3. **Valid photo-bearing Identification Document of Claimant/s**
4. **Medical Abstract/Admitting History**
5. **All available laboratory and test 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 Policyowner 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)*** *No benefit will be payable for any Major Disease contracted by the Insured within ninety (90) days from the issue date of policy contract. This Supplementary Contract or the approval date of its last reinstatement, whichever is later.* ***(7)*** *All claim documents maybe submitted through your Financial Advisor or may be sent directly to any Manulife Office nationwide.* ***(8)*** *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 OCCUPATION (LIFE INSURED)

Occupation (Job Title) ☐ Employed ☐ Self-Employed

Employer/Business Name | Estimated Gross Annual Income

Employer/Business Address

List all the major duties of your pre-disability relative to your occupation. | List the specific duties you are unable to do as of your disability.

NOTE: (1) IF YOU ARE NOT WORKING, PLEASE PROVIDE A LIST OF DAILY ACTIVITIES BEFORE AND AFTER THE DISABILITY. (2) THE COMPANY RESERVES THE RIGHT TO REQUEST FOR DOCUMENTARY EVIDENCE.

Have you ceased all work? ☐ Yes ☐ No **If yes, please provide the date you ceased all work** (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

Have you been able to do any work in any occupation since you were disabled? ☐ Yes ☐ No
If yes, please provide details.
If no, please provide details of your activities since you were disabled.

Have you sought alternative employment since leaving? ☐ Yes ☐ No If so, please give details, including any voluntary employment.

If you are self-employed:
What is the structure of your business? ☐ Sole Trader ☐ Partnership ☐ Company ☐ Trust ☐ Others

How many employees are there in your business? No. of part-time employees _____ No. of full-time employees _____

Please provide all duties of your pre-disability occupation including percentage of time spent in each.

Duties	Percentage %

How long have you been in this occupation? _____ years _____ months

Please indicate below the percentage of your day spent performing the physical activities of your occupation.

☐ Lifting 20kg or over _____ %	☐ Carrying 20kg or over _____ %	☐ Standing _____ %	☐ Kneeling _____ %	☐ Climbing (Ladders etc) _____ %
☐ Lifting 7kg or over _____ %	☐ Carrying 7kg or over _____ %	☐ Bending _____ %	☐ Sitting _____ %	

Were you employed in a supervisory capacity? ☐ Yes ☐ No
If yes, (a) what percentage of this time were you supervising? _____ %
(b) how many people did you supervise? _____

Did you travel as part of your work? ☐ Yes ☐ No
If yes, (a) how many kilometers per week? _____ %
(b) what type of vehicle? _____

What level of education do you have (secondary, tertiary, etc)?

Please specify your qualifications. Please include any courses attended skills or trade apprenticeship qualifications.

QUALIFICATIONS	YEAR COMPLETED	QUALIFICATIONS	YEAR COMPLETED

Please describe your domestic duties.

DETAILS OF DISABILITY

Type of disability benefit: ☐ Waiver of Premium of Life Insured ☐ Waiver of Premium for Payor's Benefit ☐ Total and Permanent Disability

☐ If the disability is due to illness, please provide the following details:

(a) Diagnosis

(b) Diagnosis date symptom started (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

(c) Describe in detail the exact nature of your medical condition.

☐ If the disability is due to an accident, please provide the following details:

(a) Date of Accident (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

(b) Time of Accident ☐ AM ☐ PM

(c) Details of accident.

Please provide details of all treatment that you are currently receiving including details of any regular medication being taken?

Date you last worked (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

Why did you stop to work?

Are you currently confined to: ☐ bed ☐ house ☐ hospital ☐ not applicable

Date of confinement (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

If not confined, describe briefly your daily activities.

Has there been any improvement in your condition? ☐ Yes ☐ No If yes, please describe.

Have you made any attempt to do work since the date of disability began? ☐ Yes ☐ No If yes, please give date you returned to work. (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

Are you still totally disabled? ☐ Yes ☐ No If yes, when do you expect to be able to resume your work, even in a limited way. (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

DETAILS OF PHYSICIAN(S) CONSULTED OR HOSPITAL(S) ADMITTED FOR THIS DISABILITY

NAME OF PHYSICIAN/HOSPITAL	ADDRESS	CONSULTATION		ADMISSION DATES (MM/DD/YYYY)
		REASONS	DATES	

DETAILS OF YOUR REGULAR PHYSICIAN OR ANY OTHER PHYSICIAN(S) CONSULTED FOR ANY OTHER DISORDERS IN THE PAST FIVE YEARS

NAME OF PHYSICIAN/HOSPITAL	ADDRESS	CONSULTATION		ADMISSION DATES (MM/DD/YYYY)
		REASONS	DATES	

Have you ever had this medical condition or any other similar condition before? ☐ Yes ☐ No If yes, please provide the following details.

(a) Date of Diagnosis (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

(c) Name and address of doctor
NAME ADDRESS

(b) Period off work _____

PLEASE PROVIDE DETAILS OF ALL MEDICAL TREATMENT (INCLUDING PHYSIOTHERAPY, ACUPUNCTURE, CHIROPRACTIC OR ANY OTHER PRACTICING ALTERNATIVE THERAPIES), AND CONSULTATION IN THE LAST 3 YEARS.

NAME OF PHYSICIAN/HOSPITAL	ADDRESS	REASON FOR CONSULTATION	FIRST CONSULTATION DATE (MM/DD/YYYY)

OTHER INSURANCE(S)

Are you claiming from any other insurance company in respect of this critical illness? ☐ Yes ☐ No If yes, please provide the details below.

NAME OF INSURER	POLICY NO.	POLICY EFFECTIVE DATE (MM/DD/YYYY)	TYPE OF PLAN	SUM ASSURED	CLAIM AMOUNT	CLAIM NOTIFIED YES	CLAIM NOTIFIED NO
						☐	☐
						☐	☐
						☐	☐
						☐	☐

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 _____ .

_____
Claimant Signature over Printed Name

_____
Financial Advisor/Witness Signature over Printed Name

_____
FA Code

INSTRUCTIONS AND REMINDERS

This section contains important information concerning your claim for the waiver of premium benefit due to total and permanent disability. Before you file your claim, please take a few moments to review the requirements listed on this form. By doing so, you may save yourself the time and expense of filing a claim prematurely or unnecessarily.

In order to qualify for the waiver of premium benefit due to total and permanent disability:

1) The policy must contain the waiver of premium benefit on the life of the insured filing the claim.

2) The insured must be totally and continuously disabled (uninterrupted disability for at least 6 months which prevents the Insured from engaging in his own occupation for the first 2 years and from any gainful occupation, employment or business thereafter).

3) The policy and the Total Disability Waiver (TDW) rider must be in force (premium paying) at the time of total and permanent disability.

4) The insured must furnish medical evidence of total and permanent disability.

5) If disability begins on or after age 60 and before age 65, each premium will be waived up to age 65 only and after which all premiums will then become payable. Each premium waived will be the modal premium in effect when total disability begins.

While your disability claim is pending, please continue to pay the premiums in the usual manner to keep your policy in force.

For more detailed explanation of the coverage provided by the waiver of premium provision, please refer to your TDW contract. If you have any questions concerning your policy coverage, your servicing agent will be happy to assist you or may call our **Customer Care Hotline at (02) 884-7000 or 1-800-1-888-6268 (Domestic Toll-Free).**

INSTRUCTIONS:

1) Complete and sign the Claimant's Statement (Total and Permanent Disability Claim) form. This form should be signed by the insured, if possible. If someone other than the insured signs, please indicate the relationship to the insured and address.

2) Have your physician complete the reverse side. If your current physician has not treated you from date the total and permanent disability began, obtain an additional form from any Company representation and have your previous physician complete the reverse side. Be sure to include the Insured's name and policy number(s) on the front portion of the additional forms.

3) If the claim involves loss of eyesight or limbs, complete the Claimant's Statement (Total and Permanent Disability Claim) form and have your physician complete the Attending Physician's Statement of Disability (Blindness or Severance).

4) You may also submit this form directly to any Manulife Office nationwide.