Manulife

The Manufacturers Life Insurance Co. (Phils.), Inc. Head Office: 10th Floor NEX Tower, 6786 Ayala Avenue, Makati City, 1229, Philippines Customer Care: +632 8884 7000 Domestic Toll-Free: 1 800 1 888 6268 Website: www.manulife.com.ph Email:phcustomercare@manulife.com

Claimant's Statement (Group Disability Claim)

Please print clearly. Use black ink.

Policy Number/s	Name of Life Insured (Last, First, MI)	
Email Address		Mobile Number (Country Code, Area Code, Telephone Number)

Credit	to Accoun	t Details								
Bank:	BPI	BDO	🗌 China Bank	Union Bank	Others					
Currency:	PHP	USD								
Account N	Account No Account Name									
	nake sure that yo may apply for o		details are updated and	accurate to avoid unnec	essary delay in fund	s disbursement.				
Details	s of Claim									
Name of E	Employer									
Address o	of Employer									
Regular o	ccupation immed	liately prior to bec	coming disabled							
Describe	your duties fully									
Give date	on which you las	t worked at your p	resent regular occupatio	n: (mm/dd/yyyy)						
	have returned to	work, give date of			nt returned to work, w m/dd/yyyy)	vhen do you				
Have you	filed a claim with	n any other insurar	nce company, private and	d government agency?	Yes	No If yes, complete the following:				
Name of C		-	Issue Date (n		ture of Claim					

Disability due to illness		Disability due to	accident	
Date of first symptoms noticed (mm/dd/yyyy)	Date of first consultation/treatment (mm/dd/yyyy)	t Date of accident (mm/dd/yyyy) Place of accident		cident
Examination/Treatment		Describe the injuries in	detail	
Diagnosis				
Attending Physician				
When were you first treated by a pl If so, Name and Address of Physici Name	nysician for the disability described abo an Address	ove? (mm/dd/yyyy)		
Have you consulted any other doct Names and addresses of all Physic	or because of your present disability? ians who attended the Claimant	Yes No	If yes, give details be	elow.
Name of Physician	Clinic / Hos	pital Date	e Consulted (mm/dd/yyyy)	
				Reason

Declaration and Authorization

I declare that all answers given by me in this form are true and complete, and to the best of my knowledge and belief all are based on official records.

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 or its duly authorized representative to request, secure and to obtain any or all information's, records or documents which are available from any medical practitioner, government/private hospitals/clinics, medical offices/clinics or any investigative report from its duly authorized inspection agency which will provide any applicable information concerning the processing of 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 any such physician, medical practitioner, hospital, clinic, medical office or facility and all members of its staff from any liability or obligation by reason of the release of such information/document/record.

Date Signed (mm/dd/yyyy) Place Signed		
FA Code	Date Signed (dd/mm/yyyy)	Place Signed
Documents Presented:		
B	ranch	Date (mm/dd/yyyy)
	FA Code	FA Code Date Signed (dd/mm/yyyy)