Manulife

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# Claimant's Statement
## (Health Benefit)

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 Account Details

Bank: ☐ BPI ☐ BDO ☐ China Bank ☐ Union Bank ☐ Others _____

Currency: ☐ PHP ☐ USD

Account No. _____ Account Name _____

- Please make sure that your bank account details are updated and accurate to avoid unnecessary delay in funds disbursement.
- Charges may apply for other banks.

## Details of Claim

| Type of benefit 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: _____

## Requirements

1. Claimant's Statement (Health Benefit) form
2. Attending Physician's Statement
3. Photocopy of valid photo-bearing Identification Document of Claimant/s with 3 specimen signatures
4. Applicable Receipts including Billing and Statement of Account
5. Medical Abstract / Admitting History (Detailed/Itemized)
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 1 800 888 6268 (Domestic Toll-Free).

## 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 industry association database, 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 duly authorized representatives, 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.

_____
Claimant's Signature over Printed Name

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Financial Advisor/Witness Signature over Printed Name | FA Code | Date Signed (mm/dd/yyyy) | Place Signed |

## For Manulife Use Only

Valid IDs: Type: _____ ID#: _____ ☐ Documents Presented: _____

Documents received and validated by: _____ _____ _____
Name of CSO Branch Date (mm/dd/yyyy)