Manulife

The Manufacturers Life Insurance Co. (Phils.), Inc.
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Claimant's Statement
(Living Needs 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.

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) _____

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?

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.

_____
Policyowner/Claimant Signature over Printed Name

_____
Financial Advisor/Witness Signature over Printed Name

_____
Date Signed (mm/dd/yyyy)

_____ _____ _____
Financial Advisor Code Date Signed (mm/dd/yyyy) Place Signed

_____
Place Signed

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

Requirements

1. Claimant's Statement (Living Needs Benefit) form
2. Photocopy of valid photo-bearing Identification Document of Claimant/s with 3 specimen signatures.
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 +634-8884-7000 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 Date Signed (mm/dd/yyyy) Place Signed

_____ _____
Financial Advisor/Witness Signature over Printed Name FA Code

For Manulife Use Only

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

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