Manulife

The Manufacturers Life Insurance Co. (Phils.), Inc.
Head Office: 10thFloor 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 Accident Benefit)

In this form, the "**Company**" means the Manufacturers Life Insurance Co. (Phils.).
Please read all instructions and reminders at the end before completing the form. Print clearly using black ink and countersign any corrections or erasures.

Claimant's Information

Claimant's Name (Last Name, First Name, Middle Name □ Do not know / not applicable) | Date of Birth (mm/dd/yyyy) | Sex (M/F)

Email Address | Place/Country of Birth | Citizenship/Nationality (indicate all)

Mobile Number (Country Code + Area Code + Telephone Number) | Mailing Address (Number, Street, Apartment/Suite No., Barangay/Town, Municipality/City State, Country, Zip Code)

Credit to Account Details

Bank: □ BPI □ BDO □ China Bank □ Union Bank □ Others

Currency: □ PHP □ USD □ Bank Branch _____

Account Name*: _____ Account Number*: _____

*__REMINDER__: Please make sure that your bank account details are updated and accurate to avoid unnecessary delay in disbursement of funds. Please provide proof of bank account (can be a picture/screenshot of the passbook's or online bank account's account information or customer details section) showing the complete bank account holder's name and account number. Charges may apply for other banks.

Details of Claim

Date of Accident (mm/dd/yyyy) _____ Place of Accident _____

Describe in detail how the accident happened

Describe the extent of the injury/ies

What was the diagnosis?

Date you last worked as a result of the accident: _____ (mm/dd/yyyy)

Date returned or expected to return to work: _____ (mm/dd/yyyy)

Declarations and Authorization

I hereby certify that the above statements are true and complete to the best of my knowledge and belief.

I authorize Manulife and/or its duly authorized representatives to request and secure any or all information, records or documents which are available from any medical practitioner, government or private hospital/clinic, medical offices or clinics in relation to the processing of the accident benefit claim. I agree that a photographic copy of this authorization shall be valid as the original. This also discharges any such physician, medical practitioner, hospital clinic, medical oice or facility and all members of its staff from any liability or obligation by reason of the release of such information/document/records.

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.

_____ Claimant's Signature over Printed Name

_____ Financial Advisor/Witness Signature over Printed Name

_____ Place Signed | _____ Date Signed (mm/dd/yyyy)

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

For Manulife Use Only

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

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

Claimants Authorization

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, record custodian, medical secretary, insurance or reinsuring company, medical information database or any other public or private company, entity, government agency, individual, financial institutions or persons, having information available as to diagnosis, treatment and prognosis, with respect to any physical or mental examination or condition or treatment of _____ to give to the Company or its authorized representatives, any and such all information, to independently verify, the correctness of the collected data, authenticity of the identification, supporting documents, and any other information I submitted to the Company as may be required by this claim.

I agree that a photographic copy of this authorization shall be considered valid as the original. This authorization discharges any of the above enumerated parties or their authorized staff members from any responsibility or obligation in connection with the release of such record or information.

Claimant Signature over Printed Name

Financial Advisor/Witness Signature over Printed Name

FA Code

Date Signed (MM/DD/YYYY)

Declarations and Signatures

I declare that all the answers and statements herein are true, complete and correct according to my personal knowledge and based on official records. I also allow the Company to update my records based on the information found in this form and to use such to administer and service the policy. I understand that the furnishing of this claim form and other forms by the Company do not constitute an admission that there is any insurance in force nor any liability for the payment of the benefits provided in the policy or plan. 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.

By instructing the Company to directly credit the claim proceeds to my specified bank account number or policy (if applicable) and by accepting the Company's payment of this claim through such direct credit of the proceeds or through check, I , for myself and on behalf of my heirs, relatives, assigns and successors-in- interest hereby absolutely, fully and completely release, discharge and hold free and harmless the Company and its directors, officers and duly authorized representative from any and all liabilities, responsibilities, demands, claims expenses and causes of action, in law or in equity, as may arise in connection with this claim or any payment related thereto. I further acknowledge that in the event that an action, demand, complaint, suit, claim or grievance is brought against the Company, its directors, officers, authorized representatives or employees in connection with this claim and payment, this declaration shall be presented in any court or administrative agency, to cause immediate dismissal and that I shall defend the Company and truly answer all costs and expenses, including attorney's fees, interest, penalties and other damages arising from such litigation or suit to which the Company may be entitled, including all other persons having interests therein or thereby.

I warrant that I fully understand the foregoing statements, and I voluntarily executed this release, waiver and quitclaim as my own free act and deed without any duress or intimidation on the part of any person.

The Company collects and uses any 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 the information I provided and any subsequent changes to it (including the information of third parties), with the consent of the data subject concerned can be processed, collected, shared, used, stored or transferred by the Company, including its shareholders, directors and employees, affiliates, subsidiaries, business partners, any member of the Manulife Financial Group (including those located overseas), advisors, representatives, industry associations and databases, local and foreign authorities having jurisdiction over companies within the Manulife Financial Group, external auditors/counsels, 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 and Notice available at https://www.manulife.com.ph/Customer-Privacy-Policy for purposes of:

- Underwriting and approving my application;
- Administering, servicing and reinsuring my policy;
- Marketing (including marketing of products and services offered by any member of the Manulife Financial Group and those of our business partners), promoting, getting feedback on our products and services, and measuring client satisfaction;
- Conducting data analytics and doing automated data processing or decision;
- Preventing money laundering or terrorist financing activities;
- Complying with reportorial and regulatory requirements of both local and foreign regulatory authorities (including local and foreign tax authorities and stock exchanges) as well as other legal, regulatory or contractual obligations of any members within the Manulife Financial Group, relating to information sharing, tax reporting or otherwise;
- The Company's internal purposes such as governance, risk, actuarial, claims and underwriting management, and reporting; and
- For other reasonable purposes related to the services provided.

United Nations Security Council Resolution Consent Clause:

During the effectivity of the contract/policy, I agree to the following: in case the Company is unable to comply with relevant customer due diligence (CDD) measures, as required under the Anti-Money Laundering Act, as amended and relevant issuances, due to my fault, the Company may apply the following: (a) measures to restrict the services available or prohibit any further transactions on the contract/policy until full and proper CDD measures have been successfully conducted; and (b) in case the foregoing is unsuccessful, terminate business relationship, which shall only entitle me to receive the unused portions of premium or withdrawal value, if any, whichever is applicable. I also agree to be bound by obligations set out in relevant United Nations Security Council Resolutions relating to the prevention and suppression of proliferation financing of weapons of mass destruction, including the freezing and unfreezing actions as well as prohibitions from conducting transactions with designated persons and entities.

Claimant's Signature over Printed Name

Financial Advisor/Witness Signature over Printed Name

Place Signed

Date Signed (mm/dd/yyyy)

Financial Advisor Code

Date Signed (mm/dd/yyyy)

Settlement

If the benefits/proceeds of the policy or policies are payable in a single sum, you can have us pay the whole or any portion of such proceeds with any of the following **Settlement Options:**

OPTION 1, Leave on Deposit: The proceeds will be let with us as a deposit to accumulate at interest subject to your withdrawal from time to time but not more frequently than monthly until all the proceeds with interest are exhausted.

OPTION 2, Interest Payments: You may withdraw the interest earned on the proceeds let with us from time to time but not more frequently than monthly. Interest left with us will be added to the principal and included in computing interest.

OPTION 3, Fixed Period: We will pay equal installments for a period you specify until the proceeds with interest are exhausted. The period during which the installments will be payable must not be less than one year and not more than 30 years.

OPTION 4, Fixed Installments: We will pay specified amount of installments until the proceeds with interest are exhausted.

OPTION 5, Life Annuity with Period Certain: We will pay for equal installments, during your lifetime. If you die before we have paid installments for 10 or 20 years, we will pay installments for the remainder of that period as they fall due. You specify the certain period when choosing this option.

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

Attending Physician's Statement
(Group Accident Benefit)

Policy Number	Claimant's Name (Last, First, MI)

Physician's Information

Name of Physician (Last, First, MI)

Hospital Address (Number, Street, Bldg, Barangay, Town/City, State, Country, ZIP Code)

Email Address	Mobile Number (Country Code + Area Code + Telephone Number)

Details of Claim

How long have you known the insured? _____ When did the insured/claimant first consult you for the injury (mm/dd/yyyy) _____

What was the cause of the injury? _____

Was the patient admitted to the hospital? ☐ Yes ☐ No

Date of Admission (mm/dd/yyyy) _____ Time Admitted _____ ○ AM ○ PM

Date of Discharge (mm/dd/yyyy) _____

Diagnosis _____

How long would it take for the insured to recover? _____

Prognosis _____

Is there any surgical procedure performed? ☐ Yes ☐ No

If yes, please describe the surgical procedure performed in detail. Include a copy of Pathology Result and Operation Room Record.

What is your assessment of the patient's condition? Please include results of and complication/s (if any) from the treatment of the injury.

Date the insured last reported to work as a result of the accident (mm/dd/yyyy) _____

Date the insured returned or is expected to return to work (mm/dd/yyyy) _____

How do you assess the insured's injury? Choose one below.

- ☐ a. Total Permanent Disability (If the insured is prevented from engaging in any gainful occupation for which he is or becomes reasonably fitted by education, training or experience)
- ☐ b. Temporary Total Disability (If the insured is prevented from performing all duties pertaining to his occupation)
- ☐ c. Temporary Partial Disablement (If the insured is prevented from performing one or more duties pertaining to his occupation)
- ☐ d. Hospital Indemnity (If the ensured is admitted to a licensed hospital as a result of an accident)

Declarations and Certification

I hereby certify that the above statements are true and complete to the best of my knowledge and belief.

I authorize Manulife's Medical Doctor or any of his authorized representatives or other person in Manulife's employ, or under contract with Manulife to request and/or secure from me or any medical practitioner/facility/hospital/clinic or any entity the medical records of the Insured (above-named patient). I agree that a photographic copy of this authorization shall be valid as the original.

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.

Physician's Signature over Printed Name	PRC Number / PTR Number	Date (mm/dd/yyyy)	Place Signed
Financial Advisor/Witness Signature over Printed Name	FA Code	Date (mm/dd/yyyy)	