Manulife

Dear Mr. / Ms. _____ :

We are sorry to learn of your illness/injury.

In order for us to process the claim, we require the following:

1. Hospital Income Benefit Form
2. Attending Physician's Statement
3. Billing Statement
4. All available laboratory and tests results (as specified on the Attending Physician's Statement)
5. Medical Abstract / Admitting History
6. Valid Identification Document

Upon receipt of **ALL** the above required documents, we will process your claim and inform you of the outcome as soon as possible.

If you need any assistance, please contact our Claims & Settlement Department at 884-5433 local 1146 or at 884-5427 / 884-5429.

Attached are the Hospital Income Benefit and Attending Physician's Statement forms.

Notes:

I. Please note that the fee for completing the Attending Physician's Statement shall be at the expense of the insured / policyowner.

II. If you are asking another party to handle the claim process on your behalf, an authorization letter is required.

III. Please continue to pay the premiums.

IV. All claim documents maybe submitted personally at our office or through your servicing agent or by post.

Very truly yours,

_____

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HOSPITAL INCOME BENEFIT FORM

Note:

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).

Policy Number/s

Claim Number

1. PERSONAL PARTICULARS OF POLICYHOLDER

Name: _____ Passport/ID No _____

Date of Birth _____ Age: _____ Sex: _____ Office Telephone No. _____

Address _____ Home Telephone No. _____

_____ Mobile No. _____

2. DETAILS OF ILLNESS

a. Reason of your confinement _____

a. Describe in detail all symptoms and/or nature of your illness.

_____

_____

b. Date when you first experienced these symptoms. ____ / _____ / _____
dd mm yyyy

c. How long had you been having these symptoms before you consulted a doctor? _____

d. Date when you first consulted a doctor. _____ / _____ / _____
dd mm yyyy

e. What was the diagnosis? _____

DECLARATION 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.

Dated at _____ this _____ 20 _____

Signature of Policyholder / Claimant

Signature of Witness / Agent

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ATTENDING PHYSICIAN'S STATEMENT
HOSPITAL INCOME BENEFIT

Patient's Name

Attending Physician's Name **Address**

This section must be completed by a qualified and registered physician at the expense of the claimant.

The above name is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **HOSPITAL INCOME BENEFIT**. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

A. GENERAL INFORMATION

1. Are you the patient's usual medical doctor? ☐ Yes ☐ No

   If yes, over what period do your records extend to? Start date _____ / _____ / _____ (dd / mm / yyyy)

   End date _____ / _____ / _____ (dd / mm / yyyy)

2. When did the patient first consult you for this condition? _____ / _____ / _____ (dd / mm / yyyy)

3. Please state symptoms presented and date symptoms first appeared.

   What / Who is the source of this information? _____

4. In your opinion what were the likely durations of the patient's symptoms? Please provide reasons.

5. Did the patient consult any other doctors for these symptoms before she consulted you? ☐ Yes ☐ No
   If yes, please provide details below.

6. Please provide the details below when you were consulted.

Dates Attended	Complaints & Physical Examination Findings	Duration of Illness	Diagnosis	Describe Treatment/ Procedure

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7. Please state name and address of hospital _____

_____

Date of Admission _____ Date Discharged _____ No. of Days _____

Complaint/s _____

_____

Was patient given care at the ICU? ☐ Yes ☐ No

If yes, please provide period covered/number of days(must be supported with hospital bill) _____

Final Diagnosis _____ Prognosis _____

In your opinion, when is the patient expected to return to his usual occupation or employment? _____

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

Name of Attending Physician (Please print)	**Degree/Specialty**
Signature	**Date Signed**
PRC Number / PTR Number	**Telephone Number (s)**

To the Attending Physician : You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.