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. Health Benefit Claim Form / Attending Physician's Statement
2. Copy of your Valid Identification Document or Passport
3. All available laboratory and tests results
4. Medical Abstract / Admitting History
5. Applicable Receipts (e.g. outpatient consultation & ambulance service fees)
6. Detailed Statement of Account

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.

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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HEALTH BENEFIT CLAIM FORM

Policy No.

Note:

1. The issue of this form or any other form(s) does not represent any admission of liability by Manulife Philippines.

Claim No.

2. This form should be completed by the Claimant. (Life insured or Policyowner as the case may be).

1. PERSONAL PARTICULARS OF LIFE INSURED

Name _____ Passport/ID No. _____

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

Address _____ Home Telephone No. _____

_____ Mobile No. _____

Present Occupation _____

_____

Relationship to Policyowner ☐ Self ☐ Spouse ☐ Others, please specify _____

2. DETAILS OF ILLNESS

a) Type of benefit you are claiming for _____

b) Describe in detail nature of your claim/symptoms of your illness.

_____

c) Date when you first experienced these symptoms. _____ / _____ / _____
dd mm yyyy

d) How long had you been having these symptoms before you consulted a doctor? _____

e) Have you previously suffered from or received treatment for a similar or related illness? ☐ Yes ☐ No
If yes, please provide the details.

_____

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3. RECORD OF MEDICAL CONSULTATIONS

Please provide the names of the doctors you had consulted in relation to your illness(es) and the addresses of their respective hospitals / clinics and dates of consultation.

Name of Doctor	Name / Address of Hospital / Clinic	Dates of First Consultation

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.

4. GENERAL

Have any of your blood relatives suffered from a similar or related illness? ☐ Yes ☐ No
If "yes", please provide the following details.

Relationship of Relative	Nature of Illness	Date Illness First Diagnosed

Do you smoke? ☐ Yes ☐ No

If "Yes", please provide the following information.

(i) How many cigarettes do you smoke per day? _____

(ii) For how long have you been smoking? _____

Do you consume alcohol?

If "Yes, please provide the following information. ☐ Yes ☐ No

(i) Type of alcohol _____

(ii) Quantity consumed per day _____

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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
HEALTH 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 **HEALTH 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 details of the consultation as an outpatient.

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

What / Who is the source of this information?_____

4. Did the patient consult any other doctors for these symptoms before he/she consulted you?
   ☐ Yes ☐ No

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If yes, please provide details below.

Name of Doctor	Name of Clinic/ Hospital and Address

5. Was the service of an ambulance used for the patient's hospital confinement? ☐ Yes ☐ No

If yes, this must be supported by an official receipt for use of an ambulance.

6. Was the patient admitted in the hospital? ☐ Yes ☐ No

If yes, please state name and address of hospital _____

_____

Complaint/s _____

Date of Admission _____ Date of Discharge _____ No. of Days _____

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

If yes, please state dates of ICU confinement: From _____ To _____ No. of Days _____
(must be supported with a hospital billing statement)

Final Diagnosis _____ Prognosis _____

7. Were there prescription drugs during the patient's hospital confinement? ☐ Yes ☐ No

If yes, this must be supported with the details/copy of drugs prescribed in the hospital billing statement.

8. Is there any Surgical Procedure Performed? ☐ Yes ☐ No

If yes, please describe the surgical procedure performed in details and attach copy of Pathology Result and copy of Operation Room Record.

_____

_____

Please state Name of Surgeon _____ Date of Surgery Performed _____

9. Was treatment as an outpatient required for the following?

Kidney Dialysis	☐ Yes	☐ No
Cancer Treatment	☐ Yes	☐ No
Stroke Treatment	☐ Yes	☐ No

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If yes, please provide details/manner of treatment.

_____

_____

10. To the best of my knowledge, do you consider her to be **TOTALLY DISABLED** (unable to work) ☐ Yes ☐ No

If yes, please provide period of Total Disability

From _____ To _____

Or give approximate date when she would be able to return to work _____

11. Please provide any other information that have a bearing to this claim.

_____

_____

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.