

## Instructions for Total and Permanent Disability Claim Form

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### NOTICE TO THE CLAIMANT:

This section contains important information concerning your claim for the waiver of premium benefit due to total and permanent disability. Before you file your claim, please take a few moments to review the requirements listed below. By doing so, you may save yourself the time and expense of filing a claim prematurely or unnecessarily.

In order to qualify for the waiver of premium benefit due to total and permanent disability:

- 1) The policy must contain the waiver of premium benefit on the life of the insured filing the claim.
- 2) The insured must be totally and continuously disabled (uninterrupted disability for at least 6 months which prevents the Insured from engaging in his own occupation for the first 2 years and from any gainful occupation, employment or business thereafter).
- 3) The policy and the Total Disability Waiver (TDW) rider must be in force (premium paying) at the time of total and permanent disability.
- 4) The insured must furnish medical evidence of total and permanent disability.
- 5) If disability begins on or after age 60 and before age 65, each premium will be waived up to age 65 only and after which all premiums will then become payable. Each premium waived will be the modal premium in effect when total disability begins.

While your disability claim is pending, please continue to pay the premiums in the usual manner to keep your policy in force.

For more detailed explanation of the coverage provided by the waiver of premium provision, please refer to your TDW contract. If you have any questions concerning your policy coverage, your servicing agent will be happy to assist you or may call our Claims & Settlement Department at Tel. No. (632) 884-5427 or 884-5429 or toll free at 1-800-1888-6268.

### Instructions:

- 1) Complete and sign the Claimant's Statement of Total and Permanent Disability form. This form should be signed by the insured, if possible. If someone other than the insured signs, please indicate the relationship to the insured and address.
- 2) Have your physician complete the reverse side. If your current physician has not treated you from date the total and permanent disability began, obtain an additional form from any Company representation and have your previous physician complete the reverse side. Be sure to include the Insured's name and policy number(s) on the front portion of the additional forms.
- 3) If the claim involves loss of eyesight or limbs, complete the Claimant's Statement of Total and Permanent Disability and have your physician complete the Attending Physician's Statement of Disability (Blindness or Severance).
- 4) Submit completed forms to:

**Manulife**  
Claims & Settlement Department  
Ground Floor, LKG Tower  
6801 Ayala Avenue  
1226 Makati City  
Philippines



# Claimant's Statement of Total and Permanent Disability

(Please print using black or blue ink)

To: **Manulife Philippines**

Claim No.

I understand that the furnishing of this claim form and other claim forms by the Company does not constitute an admission that there is any insurance in force nor any liability for payment of the benefits provided in the policy contract.

Notes:

A waiting period of 6 months from the date of disability must elapse before a disability claim will be considered.

**1. PARTICULARS**

Name of Life Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number/s \_\_\_\_\_

Policy Number/s \_\_\_\_\_

**2. DETAILS OF OCCUPATION**

(a) Occupation (Job Title) \_\_\_\_\_

Employed                       Self Employed

Name of Employer \_\_\_\_\_

Address of Employer \_\_\_\_\_

(b) Telephone Number/s \_\_\_\_\_

(c) Monthly Income \_\_\_\_\_

(d) List all the major duties of your pre-disability relative to your occupation.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(e) List the specific duties you are unable to do as of your disability.

\_\_\_\_\_

\_\_\_\_\_

Note: (i) If you are not working, please provide a list of daily activities before and after the disability.

(ii) The Company reserves the right to request for documentary evidence.



(n) Please indicate below the percentage of your day spent performing the physical activities of your occupation.

<b>Activities</b>	<b>Percentage</b>	<b>Activities</b>	<b>Percentage</b>
Lifting 20kg or over	_____ %	Climbing (Ladders etc)	_____ %
Lifting 7kg or over	_____ %	Bending	_____ %
Carrying 20kg or over	_____ %	Kneeling	_____ %
Carrying 7kg or over	_____ %	Sitting	_____ %
Standing	_____ %		

(o) Were you employed in a supervisory capacity?  Yes  No

If yes, (i) what percentage of this time were you supervising? \_\_\_\_\_%

(ii) how many people did you supervise? \_\_\_\_\_

(p) Did you travel as part of your work?  Yes  No

If yes, (i) how many kilometers per week? \_\_\_\_\_

(ii) what type of vehicle? \_\_\_\_\_

(q) What level of education do you have (secondary, tertiary, etc)? \_\_\_\_\_

(r) Please specify your qualifications. Please include any courses attended skills or trade apprenticeship qualifications.

<b>QUALIFICATIONS</b>	<b>YEAR COMPLETED</b>
_____	_____
_____	_____
_____	_____

(s) Please describe your domestic duties.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





(e) Are you currently confined to:  bed  house  hospital  Not Applicable

If "Yes", state the period of confinement. ? \_\_\_\_\_

If not confined, describe briefly your daily activities. \_\_\_\_\_

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(f) Has there been any improvement in your condition? If yes, please describe.

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(g) Have you made any attempt to do work since the date of disability began? If yes, please give date you returned to work.

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(h) Are you still totally disabled?  Yes  No

If yes, when do you expect to be able to resume your work, even in a limited way?

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**4. DETAILS OF PHYSICIAN(S) CONSULTED OR HOSPITAL(S) ADMITTED FOR THIS DISABILITY**

Name of Physician / Hospital	Address	Consultation		Admission Dates
		Reasons	Dates	

**5. DETAILS OF YOUR REGULAR PHYSICIAN OR ANY OTHER PHYSICIAN(S) CONSULTED FOR ANY OTHER DISORDERS IN THE PAST FIVE YEARS**

Name of Physician / Hospital	Address	Consultation		Admission Dates
		Reasons	Dates	



(a) Have you ever had this medical condition or any other similar condition before?

Yes  No

If yes, please provide the following details.

(i) Date of Diagnosis \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (ii) Period off work \_\_\_\_\_  
dd mm yyyy

(iii) Name and address of doctor \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(b) Please provide details of all medical treatment (including physiotherapy, acupuncture, chiropractic or any other practicing alternative therapies), and consultation in the last 3 years.

(i) Date first consulted \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

Name \_\_\_\_\_ Qualifications \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Reason for consultation \_\_\_\_\_

(ii) Date first consulted \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

Name \_\_\_\_\_ Qualifications \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Reason for consultation \_\_\_\_\_

**6. OTHER INSURANCE(S)**

Name Insurer	of	Policy Number	Policy Effective Date	Type of Plan	Sum Assured	Claim Amount	Claim Notified (Yes/No)



## DECLARATION AND AUTHORIZATION

I declare that all answers and statements given by me are true, complete & correct according to my personal knowledge & belief.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, record custodian, medical secretary, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, entity or employer, having information available as to diagnosis, treatment and prognosis, with respect to any physical or mental examination or condition of treatment of \_\_\_\_\_, to give to **MANULIFE PHILIPPINES** or its legal representative, any and such all information. (Name of 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 CLAIMANT**

\_\_\_\_\_  
**SIGNATURE OF WITNESS/AGENT**