Manulife

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Claimant's Statement
(Group Disability Claim)

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.

Details of Claim

Name of Employer

Address of Employer

Regular occupation immediately prior to becoming disabled

Describe your duties fully

Give date on which you last worked at your present regular occupation: (mm/dd/yyyy) _____

☐ If you have returned to work, give date of return: (mm/dd/yyyy) _____

☐ If you have not returned to work, when do you expect to? (mm/dd/yyyy) _____

Have you filed a claim with any other insurance company, private and government agency? ☐ Yes ☐ No If yes, complete the following:

Name of Company	Issue Date (mm/dd/yyyy)	Nature of Claim

☐ Disability due to illness

Date of first symptoms noticed (mm/dd/yyyy) _____ Date of first consultation/treatment (mm/dd/yyyy) _____

Examination/Treatment

Diagnosis

Attending Physician _____

☐ Disability due to accident

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

Describe the injuries in detail

When were you first treated by a physician for the disability described above? (mm/dd/yyyy) _____

If so, Name and Address of Physician

Name _____ Address _____

Have you consulted any other doctor because of your present disability? ☐ Yes ☐ No If yes, give details below.

Names and addresses of all Physicians who attended the Claimant

Name of Physician	Clinic / Hospital	Date Consulted (mm/dd/yyyy)	Reason

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

For Manulife Use Only

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

Documents received and validated by: _____ _____ _____

Name of CSO | Branch | Date (mm/dd/yyyy)