Manulife

The Manufacturers Life Insurance Co. (Phils.), Inc.
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Claimant's Statement
(Group Major Disease/Critical/Terminal Illness)

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

Reason of Confinement _____

Describe in detail the nature of your claim/symptoms of your illness/injury:

Date when you first experience these symptoms (mm/dd/yyyy) _____

Describe in details how the accident happened:

Date when you first consulted a doctor (mm/dd/yyyy) _____

What was the diagnosis?

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

Provide details of the doctors you had consulted in relation to your illness:

Name of Doctor	Name / Address of Hospital / Clinic	Dates of First Consultation (mm/dd/yyyy)	Telephone Number

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

Relationship of Relative	Nature of Illness	Dates Illness First Diagnosed (mm/dd/yyyy)

Are you claiming from any other insurance company in respect of this critical illness? ☐ Yes ☐ No If yes, please provide the details below.

Name of Company	Policy Number/s	Face Amount

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 industry association database, 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 duly authorized 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

_____	_____	_____	_____
Financial Advisor/Witness Signature over Printed Name	FA Code	Date Signed (mm/dd/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)