Manulife China Bank
LIFE ASSURANCE CORPORATION
a joint venture between Manulife Philippines and China Banking Corporation

Manulife China Bank Life Assurance Corporation
Head Office: 10th Floor NEX Tower, 6786 Ayala Avenue, Makati City, 1229 Philippines
Customer Care: +632 8884-7000
Domestic Toll-Free: 1-800-1-888-6268
Website: www.manulife-chinabank.com.ph
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Instructions for Total and Permanent Disability Claim Form

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, NEX Tower
6786 Ayala Avenue
1229 Makati City
Philippines

Claimant's Statement of Total and Permanent Disability

(Please print using black or blue ink)

Claim No.

To: Manulife Philippines

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.

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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.

(f) Have you ceased all work ? ☐ Yes No ☐

(g) If yes, please provide the date you ceased all work. ________ / ____________ / ____________
dd mm yyyy

(h) Have you been able to do any work in any occupation since you were disabled?

☐ Yes ☐ No

(i) If yes, please provide details.

____

____

If no, please provide details of your activities since you were disabled?

____

____

(j) Have you sought alternative employment since leaving? ☐ Yes ☐ No

If so, please give details, including any voluntary employment

____

____

(k) If you are self-employed:

(i) What is the structure of your business?

☐ Sole Trader ☐ Partnership ☐ Company

☐ Trust ☐ Others

(ii) How many employees are there in your business?

No. of part-time employees __________________

No. of full- time employees __________________

(l) Please provide all duties of your pre-disability occupation including percentage of time spent in each.

Duties	Percentage%
______________________________	____________
______________________________	____________

(m) How long have you been in this occupation? ________________years ________________months

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

Activities	Percentage	Activities	Percentage
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.

QUALIFICATIONS	YEAR COMPLETED
________________________________	____________________
________________________________	____________________
________________________________	____________________

(s) Please describe your domestic duties.

____

____

____

3. DETAILS OF DISABILITY

(a) Type of disability benefit:

☐ Waiver of Premium of Life Insured

☐ Waiver of Premium for Payor's Benefit

☐ Total and Permanent Disability

(b) If the disability is due to illness, please provide the following details:

(i) Diagnosis ____

(ii) Diagnosis Date symptom started ________ / ________ / ________
dd mm yyyy

(iii) Describe in detail the exact nature of your medical condition.

____

____

(c) If the disability is due to an accident, please provide the following details:

(i) Date of Accident ______ / ________ / ______(ii) Time of Accident ______ am/pm
dd mm yyyy

(iii) Details of accident ____

____

____

(d) Please provide details of all treatment that you are currently receiving including details of any regular medication being taken?

____

____

____

____

Date you last worked ______ / ________ / ______
dd mm yyyy

Why did you stop to work? ____

____

____

(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. ______________________________

____

____

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

____

____

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

____

____

(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?

____

____

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 of Insurer	**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**