Manulife | Chinabank

LIFE ASSURANCE CORPORATION

The Manufacturers Life Insurance Co. (Phils.), Inc.
Head Office: 10th Floor NEX Tower, 6786 Ayala Avenue, Makati City, 1229, Philippines
Customer Care: +632 8884 7000
Domestic Toll-Free: 1 800 888 6268
Website: www.manulife.com.ph
Email:phcustomercare@manulife.com

Claimant's Statement (Group Death Claim)

Policy Number/s

In this form, the "**Company**" means the Manulife China Bank Life Assurance Corporation.
Please read all instructions and reminders at the end before completing the form. Print clearly using black ink and countersign any corrections or erasures.

Claimant's Name (Last Name, First Name, Middle Name ☐ Do not know / not applicable)	Date of Birth(MM/DD/YYYY)	Sex (M/F)	Place/Country of Birth	Citizenship/Nationality (indicate all)

Email Address	Contact Number Mobile: (Country Code) (Mobile No.)

Claimant's Address (Number, Street, Apartment/Suite No., Barangay/Town, Municipality/City, State, Country. ZIP Code)

Credit to Account Details

Bank: ☐ BPI ☐ BDO ☐ China Bank ☐ Union Bank ☐ Others

Currency: ☐ PHP ☐ USD ☐ Bank Branch _____

Account No. _____ Account No. _____

*Please make sure that your bank account details are updated and accurate to avoid unnecessary delay in funds disbursement. Provide proof of account (can be a picture of passbook or screen snapshot of online banking account) indicating the complete bank account name and account number. Charges may apply for other banks.

Declarations and details of claim

Full Name of Deceased (Last Name, First Name, Middle Name ☐ Do not know / not applicable)

Residence of Deceased	Occupation of Deceased

Date of Death (MM/DD/YYYY)	Place of Death	Cause of Death

Place of Interment	Date of Interment (MM/DD/YYYY)	Date the Deceased first complained of last illness (MM/DD/YYYY)	Give indications

State Deceased's insurance with other companies

Name of Company	Policy No.	Face Amount

In what capacity do you claim the insurance?

☐ Named Beneficiary
☐ Assignee
☐ Trustee of Minor Beneficiary
☐ Others _____

I am the Deceased's (state your relationship to the Deceased) _____

Are you 18 years old or over? ☐ Yes ☐ No
If not, give Date of Birthday (MM/DD/YYYY)

If an entity claimant, does this policy have a beneficial owner? ☐ Yes, please submit Beneficial Owner form ☐ No

If an individual claimant, have you or any of your immediate family members or close relationships and associates been entrusted with prominent public position/s in (a) the Philippines with substantial authority over policy, operations or the use or allocation of government-owned resources; (b) a foreign State; or (c) an international organization? ☐ Yes ☐ No

Is the Claimant a United States citizen, resident or a resident alien (US Green card holder)? ☐ Yes to any, please provide W-9 form (If yes, please skip questions below.) ☐ No

Does the Claimant have a United States Taxpayer Identification Number (SSN/TIN), address and/or telephone number? ☐ Yes, please provide W8-BEN form ☐ No

Or was the Claimant born in the US and renounced his US Citizenship?

☐ Yes, please provide W8-BEN form and US Bureau of Consular Affairs' Certificate of Loss of Nationality in the US form ☐ No

If you are filling this claim on behalf of minor beneficiary/ies, have you been disqualified by any court of law from exercising the right to administer the property of such minor? ☐ Yes ☐ No

Choose from the Settlement Options below for payment of benefits. Refer to reverse side for details of below

☐ Lump Sum ☐ Fixed Installments ☐ Fixed Period ☐ Others
☐ Interest Payments ☐ Leave on Deposit ☐ Life Annuity with Period Certain _____

NAMES AND ADDRESSES OF ALL PHYSICIANS WHO ATTENDED THE DECEASED

Name	Address	Date (MM/DD/YYYY)	Reason/Treatment

NAMES AND LOCATIONS OF ALL HOSPITALS/CLINICS WHERE THE DECEASED WAS TREATED

Hospital/Clinic	City/Town	Date (MM/DD/YYYY)	Reason/Diagnosis

Claimants Authorization

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, record custodian, medical secretary, insurance or reinsuring company, medical information database or any other public or private company, entity, government agency, individual, financial institutions or persons, having information available as to diagnosis, treatment and prognosis, with respect to any physical or mental examination or condition or treatment of _____ to give to the Company or its authorized representatives, any and such all information, to independently verify, the correctness of the collected data, authenticity of the identification, supporting documents, and any other information I submitted to the Company as may be required by this claim.

I agree that a photographic copy of this authorization shall be considered valid as the original. This authorization discharges any of the above enumerated parties or their authorized staff members from any responsibility or obligation in connection with the release of such record or information.

_____
Claimant Signature over Printed Name

_____
Financial Advisor/Witness Signature over Printed Name

_____
FA Code

_____
Date Signed (MM/DD/YYYY)

Declarations and Signatures

I declare that all the answers and statements herein are true, complete and correct according to my personal knowledge and based on official records. I also allow the Company to update my records based on the information found in this form and to use such to administer and service the policy. I understand that the furnishing of this claim form and other forms by the Company do not constitute an admission that there is any insurance in force nor any liability for the payment of the benefits provided in the policy or plan. Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.
By instructing the Company to directly credit the claim proceeds to my specified bank account number or policy (if applicable) and by accepting the Company's payment of this claim through such direct credit of the proceeds or through check, I , for myself and on behalf of my heirs, relatives, assigns and successors-in- interest hereby absolutely, fully and completely release, discharge and hold free and harmless the Company and its directors, officers and duly authorized representative from any and all liabilities, responsibilities, demands, claims expenses and causes of action, in law or in equity, as may arise in connection with this claim or any payment related thereto. I further acknowledge that in the event that an action, demand, complaint, suit, claim or grievance is brought against the Company, its directors, officers, authorized representatives or employees in connection with this claim and payment, this declaration shall be presented in any court or administrative agency, to cause immediate dismissal and that I shall defend the Company and truly answer all costs and expenses, including attorney's fees, interest, penalties and other damages arising from such litigation or suit to which the Company may be entitled, including all other persons having interests therein or thereby.
I warrant that I fully understand the foregoing statements, and I voluntarily executed this release, waiver and quitclaim as my own free act and deed without any duress or intimidation on the part of any person.
The Company collects and uses any personal and sensitive information to operate an insurance business. By signing this form and continuing to avail of the Company's products and services, I agree that the information I provided and any subsequent changes to it (including the information of third parties), with the consent of the data subject concerned can be processed, collected, shared, used, stored or transferred by the Company, including its shareholders, directors and employees, affiliates, subsidiaries, business partners, any member of the Manulife Financial Group (including those located overseas), advisors, representatives, industry associations and databases, local and foreign authorities having jurisdiction over companies within the Manulife Financial Group, external auditors/counsels, and its third party service providers (whether within or outside the Philippines) within the rules set by the Data Privacy Act of 2012, as may be amended from time to time, relevant regulations and the Company's Privacy Policy and Notice available at https://www.manulife.com.ph/Customer-Privacy-Policy for purposes of:

- Underwriting and approving my application;
- Administering, servicing and reinsuring my policy;
- Marketing (including marketing of products and services offered by any member of the Manulife Financial Group and those of our business partners), promoting, getting feedback on our products and services, and measuring client satisfaction;
- Conducting data analytics and doing automated data processing or decision;
- Preventing money laundering or terrorist financing activities;
- Complying with reportorial and regulatory requirements of both local and foreign regulatory authorities (including local and foreign tax authorities and stock exchanges) as well as other legal, regulatory or contractual obligations of any members within the Manulife Financial Group, relating to information sharing, tax reporting or otherwise;
- The Company's internal purposes such as governance, risk, actuarial, claims and underwriting management, and reporting; and
- For other reasonable purposes related to the services provided.

United Nations Security Council Resolution Consent Clause:

During the effectivity of the contract/policy, I agree to the following: in case the Company is unable to comply with relevant customer due diligence (CDD) measures, as required under the Anti-Money Laundering Act, as amended and relevant issuances, due to my fault, the Company may apply the following: (a) measures to restrict the services available or prohibit any further transactions on the contract/policy until full and proper CDD measures have been successfully conducted; and (b) in case the foregoing is unsuccessful, terminate business relationship, which shall only entitle me to receive the unused portions of premium or withdrawal value, if any, whichever is applicable. I also agree to be bound by obligations set out in relevant United Nations Security Council Resolutions relating to the prevention and suppression of proliferation financing of weapons of mass destruction, including the freezing and unfreezing actions as well as prohibitions from conducting transactions with designated persons and entities.

_____
Claimant's Signature over Printed Name

_____
Financial Advisor/Witness Signature over Printed Name

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

_____ _____
Financial Advisor Code Date Signed (mm/dd/yyyy

Settlement

If the benefits/proceeds of the policy or policies are payable in a single sum, you can have us pay the whole or any portion of such proceeds with any of the following **Settlement Options:**

OPTION 1, Leave on Deposit: The proceeds will be let with us as a deposit to accumulate at interest subject to your withdrawal from time to time but not more frequently than monthly until all the proceeds with interest are exhausted.

OPTION 2, Interest Payments: You may withdraw the interest earned on the proceeds let with us from time to time but not more frequently than monthly. Interest left with us will be added to the principal and included in computing interest.

OPTION 3, Fixed Period: We will pay equal installments for a period you specify until the proceeds with interest are exhausted. The period during which the installments will be payable must not be less than one year and not more than 30 years.

OPTION 4, Fixed Installments: We will pay specified amount of installments until the proceeds with interest are exhausted.

OPTION 5, Life Annuity with Period Certain: We will pay for equal installments, during your lifetime. If you die before we have paid installments for 10 or 20 years, we will pay installments for the remainder of that period as they fall due. You specify the certain period when choosing this option.

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Attending Physician's Statement
(Group Death Claim)

Physician's Information

Policy Number	Name of Physician (Last, First, MI)

Hospital Address (Number, Street, Bldg, Barangay, Town/City, State, Country, ZIP Code)

Email Address	Mobile Number (Country Code + Area Code + Telephone Number)

Details of Claim

Full Name of Deceased (Last, First, Middle)

Date of Death (mm/dd/yyyy)	Place of Death	Cause of Death

Cause of Death
- ☐ A. Decease or condition directly leading to death
- ☐ B. Antecedent causes (morbid conditions, if any giving the rise to the above cause)
  Due to _____
- ☐ C. Other significant conditions (contributing to the death but not related to the disease or condition causing death)

Is the death due to accident, suicide or homicide? ☐ Yes ☐ No
If yes, specify and describe briefly:

Was the deceased under the influence of liquor/drugs when the accident/suicide/homicide happened? ☐ Yes ☐ No
Was there an official inquiry as to cause of death or a post-mortem examination on the body of the deceased? ☐ Yes ☐ No
If Yes, please provide the official report.
Have you seen the corpse of the Deceased? ☐ Yes ☐ No
How long have you known the deceased? _____ What were the symptoms first noticed by deceased? _____
What was your diagnosis?

Were you able to inform the deceased of your diagnosis? ☐ Yes ☐ No How long did the deceased suffered from the ailment? _____

Physicians to your knowledge who attended the deceased for any illness:

Name	Address	Date (mm/dd/yyyy)	Reason/Treatment

Condition and Illnesses to your knowledge you treated the deceased in the past three years:

Symptoms	Diagnosis	Date (mm/dd/yyyy)	Treatment

Other hospitals/clinics to your knowledge where the deceased was treated:

Hospital/Clinic	Address	Date (mm/dd/yyyy)	Diagnosis

Declarations and Certification

I hereby certify that the above statements are true and complete to the best of my knowledge and belief.

I authorize Manulife's Medical Doctor or any of his authorized representative or other person in Manulife's employ, or under contract with Manulife to request and/or secure from me or any medical practitioner/facility/hospital/clinic or any entity the medical records of the Deceased (above-named patient). I agree that a photographic copy of this authorization shall be valid as the original.

Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.

Physician's Signature over Printed Name	PRC Number / PTR Number	Date (mm/dd/yyyy)	Place Signed

Financial Adviser/Witness Signature over Printed Name	FA Code	Date (mm/dd/yyyy)

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Employer's Statement Form

Employer/Policyholder

Policy Number

Insured/Employee Information

Name (Last, First, Middle)		Position/Title
Date Hired (mm/dd/yyyy)	Regularization Date (mm/dd/yyyy)	Separation Date (mm/dd/yyyy) if applicable
Date last reported to work (mm/dd/yyyy)	Employee was on leave prior to date of event? ☐ Yes ☐ No If yes, indicate reason:	

Coverage Data

Type of Claim:

☐ Death ☐ Disability ☐ Critical/Terminal Illness

☐ Accident ☐ Hospitalization

Date of Event (mm/dd/yyyy)

Claim Amount*

*Please refer to your Group Master Policy Contract, Policy Specification Page - schedule of insurance benefits

Declarations and Authorization

I do hereby certify the truth and correctness of the above information in my capacity as the authorized representative of the Employer/Policyholder to support the claim of the Group Insurance Benefit.

Signature over Printed Name of Authorized Representative

Position/Title

Date Signed (mm/dd/yyyy)

Place Signed