Dear Mr. / Ms. _____ :

This is in connection with your claim for Female Benefit.

In order for us to process the claim, we require the following:

1. Female Benefit Claim Form
2. Attending Physician's Statement
3. Billing Statement, if applicable
4. All available laboratory and tests results (as specified in the Attending Physician's Statement)
5. Medical Abstract / Admitting History
6. Record of Operation, if applicable
7. Policy Contract, applicable for Major Disease/Critical Illness Claim only
8. Valid Identification Document

Upon receipt of above stated applicable required documents, we will process your claim and inform you of the outcome as soon as possible.

If you need any assistance, please contact our Claims & Settlement Department at 884-5433 local 1146 or at 884-5427 / 884-5429.

ttached are the Female Benefit Claim and Attending Physician's Statement forms.

Notes:

I. Please note that the fee for completing the Attending Physician's Statement shall be at the expense of the insured / policyowner.

II. If you are asking another party to handle the claim process on your behalf, an authorization letter is required.

III. All claim documents maybe submitted personally at our office or through your servicing agent or by post.

Very truly yours,

_____

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
Email:phcustomercare@manulife.com

Female Benefit Claim Form

Policy No.

Note:
1. The issue of this form or any other form(s) does not represent any admission of liability by Manulife Philippines.
2. This form should be completed by the Claimant. (Life insured or Policyowner as the case may be).

Claim No.

1. PERSONAL PARTICULARS OF POLICYHOLDER

Name _____ Passport/ID No _____

Date of Birth _____Age _____ Sex _____Office Telephone No._____

ddress _____ Home Telephone No. _____

_____ Mobile No. _____

Present Occupation _____

2. PERSONAL PARTICULARS OF LIFE INSURED (if different from above)

Name _____ Passport/ID No _____

Date of Birth _____Age _____ Sex _____Office Telephone No._____

ddress _____ Home Telephone No. _____

_____ Mobile No. _____

Present Occupation _____

3. DETAILS OF ILLNESS

a) Type of Female Benefit you are claiming for _____

b) Describe in detail nature of your claim/symptoms of your illness. _____

_____

c) Date when you first experienced these symptoms _____/ _____/ _____
dd mm yyyy

d) How long had you been having these symptoms before you consulted a doctor? _____

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

f) What was the diagnosis? _____

DECLARATION AND AUTHORIZATION

I declare that all answers given by me in this form are, to the best of my knowledge and belief, true and complete.

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 to obtain an investigative report from its duly authorized inspection agency which will provide any applicable information concerning 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 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 Policyholder / Claimant **Signature of Witness / Agent**

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Attending Physician's Statement Female Benefit

Patient's Name

_____

Attending Physician's Name _____

Address _____

This section must be completed by a qualified and registered physician at the expense of the claimant.

The above name is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **FEMALE BENEFIT**. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

A. GENERAL INFORMATION

1. Are you the patient's usual medical doctor? ☐ Yes ☐ No

   If yes, over what period do your records extend to? Start date _____ / _____ / _____ (dd / mm / yyyy)

   End date _____ / _____ / _____ (dd / mm / yyyy)

2. When did the person first consult you for this condition? _____ / _____ / _____ (dd / mm / yyyy)

3. Please state symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started

What / Who is the source of this information?_____

4. In your opinion what were the likely durations of the patient's symptoms? Please provide reasons.

   _____

   _____

5. Did the patient consult any other doctors for these symptoms before she consulted you? ☐ Yes ☐ No
   If yes, please provide details below.

Name of Doctor	Name of Clinic/ Hospital and Address

6. Please provide the details below when she consulted you.

Dates Attended	Complaints & Physical Examination Findings	Duration of Illness	Diagnosis	Describe Treatment/ Procedure

7. Has she been admitted in the hospital? ☐ Yes ☐ No

If yes, please state name of hospital / address _____

_____

Complaint/s _____

Date of Admission _____ Time _____ Date of Discharge _____ Time _____
Admitted Discharged

Diagnosis _____ Prognosis _____

☐ If admission is due to Maternity related condition, please provide the following information.

Date of Delivery _____ Number of Delivery _____

☐ Is there finding of any Pregnancy Complication? ☐ Yes ☐ No

If yes, please describe finding in details. (Please provide copies of test result/s)

_____

_____

_____

☐ Is there finding of any Congenital Anomaly? ☐ Yes ☐ No
If yes, please describe finding in details. (Please provide copies of test result/s)

_____

_____

_____

8. Is there any Surgical Procedure Performed? ☐ Yes ☐ No

If yes, please describe the Surgical procedure performed in details including Pathology Result and copy of Operation Room Record.

_____

_____

9. Assessment of her present condition (Please include sequelae/complications/results of treatment of the illness/es).

_____

_____

10. To the best of my knowledge, do you consider her to be **TOTALLY DISABLED** (unable to work) ☐ Yes ☐ No

If yes, please provide period of Total Disability

From _____ To _____

Or give approximate date when she would be able to return to work _____

11. Please provide any other information that have a bearing to this claim.

_____

_____

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

Name of Attending Physician (Please print)	**Degree/Specialty**
Signature	**Date Signed**
PRC Number / PTR Number	**Telephone Number (s)**

To the Attending Physician : You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.