Manulife | Chinabank
LIFE ASSURANCE CORPORATION
The Manufacturers Life Insurance Co. (Phils.), Inc.
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Claimant's Statement
(Group Disability Claim)

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 Information

Claimant's Name (Last Name, First Name, Middle Name ☐ Do not know / not applicable) | Date of Birth (mm/dd/yyyy) | Sex (M/F)

Email Address | Place/Country of Birth | Citizenship/Nationality (indicate all)

Mobile Number (Country Code + Area Code + Telephone Number) | Mailing 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 Name _____

*__REMINDER__: Please make sure that your bank account details are updated and accurate to avoid unnecessary delay in disbursement of funds. Please provide proof of bank account (can be a picture/screenshot of the passbook's or online bank account's account information or customer details section) showing the complete bank account holder's name and account number. 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 or 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) _____

☐ Disability due to accident

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

Examination/Treatment	Describe the injuries in detail
Diagnosis	
Attending Physician _____	

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

Declarations and Authorization

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

For Manulife Use Only

_____ ID#: _____ Documents Presented: _____

Valid IDs: Type:

_____ _____ _____
Documents received and validated by: Name of CSO Branch Date (mm/dd/yyyy)

Form No. MCBL GA CSDC (v. 06/2026)