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 Major Disease / Critical Illness / Terminal Illness)

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 Name*: _____ Account Number*: _____

*__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

Reason for 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 detail 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 have consulted in relation to your illness:

Name of Doctor	Name/ Address of Hospital/ Clinic	Date of First Consultation (mm/dd/yyyy)	Contact 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

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)

For Manulife Use Only

Valid IDs: Type: _____ ID#: _____ ☐ Documents Presented: _____

Documents received and validated by: _____ _____ _____

Name of CSO Branch Date (mm/dd/yyyy)

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Attending Physician's Statement

(Group Major Disease / Critical Illness / Terminal Illness)

Policy Number	Claimant's Name (Last, First, MI)

Physician's Information

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

How long have you known the insured? _____ When did the insured/claimant first consult you for the injury (mm/dd/yyyy) _____

Symptoms presented at first consultation	Date symptoms first started (mm/dd/yyyy)	Duration of the symptoms

Consultation Details (include other instances of consultation, if any):

Date (mm/dd/yyyy)	Complaints & Physical examination findings	Duration of illness	Diagnosis	Describe treatment/procedure

Other physicians to your knowledge who attended the claimant:

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

	Yes	No
Was the patient admitted in the hospital?	☐	☐

Admission Date (mm/dd/yyyy) _____ Time _____ ○ AM ○ PM

Discharge Date (mm/dd/yyyy) _____ Time _____ ○ AM ○ PM

Major Complaint/s

Does the patient have Human Immunodeficiency Virus (HIV) infection when diagnosed with the critical/terminal illness? If yes, provide date of diagnosis for HIV and attach a copy of the HIV confirmatory blood test report (if any).	☐	☐

Provide full details of current condition and treatment. What is the expected impact on the patient's survival?

What is the prognosis?

Has active treatment and therapy now been rejected in favor of relief of symptoms? If yes, provide details why this opinion or course of action is taken.	☐	☐

In your opinion, how long is the expectancy of the patient? _____months
Provide explanation and give supporting medical evidence to substantiate your opinion.

In your opinion, is the patient's condition incurable and beyond any hope of recovery?	☐	☐
In your opinion, is the advent of death highly probable within 6 months from the date of diagnosis?	☐	☐
In your opinion, is the advent of death highly probable within 12 months from the date of diagnosis?	☐	☐
Is the patient currently admitted in a hospital, nursing home or hospice? If yes, provide name and address of the institution.	☐	☐

Provide details of all investigation/test performed and attach copies of diagnostic and other relevant hospital reports.

Medical History

Has the patient previously suffered from the condition specified above or any related illnesses?	☐	☐
Is there anything in the patient's medical history which would have increased the risk of the condition resulting to Terminal Illness?	☐	☐

Provide details of the patient's family history, which would increase the risk of the condition resulting in resulting in Terminal Illness (including the relationship, nature of illness and date of diagnosis):

Does the patient have or ever had other significant health conditions?	☐	☐

Provide any other additional information that will enable the company to assess this claim. Use additional sheets of paper if more space is needed for the information.

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 representatives 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 Insured (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 ine 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)	
Financial Advisor/Witness Signature over Printed Name	FA Code	Date (mm/dd/yyyy)	Place Signed