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
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Claimant's Statement
(Total And Permanent 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 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 Occupation

Occupation (Job Title)	☐ Employed ☐ Self-Employed	Estimated Gross Annual Income

Employer/Business Name	Employer/Business Address

List all the major duties of your pre-disability relative to your occupation.

Duties	Percentage %

List the specific duties you are unable to do as of your disability.

Duties	Percentage %

Note: (1) If you are not working, please provide a list of daily activities before and after the disability. (2) The Company reserves the right to request documentary evidence.

Have you ceased all work? ☐ Yes ☐ No If yes, please provide the date you ceased all work (mm/dd/yyyy) _____

List of activities you do since you were disabled.

Have you been able to do any work in any occupation since you were disabled? ☐ Yes ☐ No
If yes, please provide details.

Have you sought alternative employment since leaving? ☐ Yes ☐ No If so, please give details, including any voluntary employment.

If you are self-employed:
What is the structure of your business? ☐ Sole Trader ☐ Partnership ☐ Company ☐ Trust ☐ Others _____

How many employees do you have? No. of part-time employees _____ No. of full-time employees _____

Indicate the percentage of your day spent performing the physical activities of your occupation (pre-disability):

☐ Lifting 20kg or over ____% ☐ Carrying 20kg or over ____% ☐ Standing ____% ☐ Kneeling ____% ☐ Climbing (Ladders etc) ____%
☐ Lifting 7kg or over ____% ☐ Carrying 7kg or over ____% ☐ Bending ____% ☐ Sitting ____%

Were you employed in a supervisory capacity? ☐ Yes ☐ No
If yes, what percentage of this time were you supervising? ____%
How many people did you supervise? ____

Did you travel as part of your work? ☐ Yes ☐ No
If yes, how many kilometers per week? ____%
What type of vehicle?

Educational Attainment: _____

Please specify your qualifications. Please include any courses attended skills or trade	QUALIFICATIONS	YEAR COMPLETED	QUALIFICATIONS	YEAR COMPLETED
apprenticeship qualifications.				

Please describe your domestic duties.

Details of Disability

Is the disability due to illness? ☐ Yes ☐ No
If yes, what is the diagnosis?

Date symptoms started (mm/dd/yyyy) _____
Describe in detail the exact nature of your medical condition.

Is the disability due to an accident? ☐ Yes ☐ No
If yes, provide date and time of the accident
Date (mm/dd/yyyy) _____ Time _____

Details of accident

Please provide details of all treatment that you are currently receiving including details of any regular medication being taken.

Did you stop working? ☐ Yes ☐ No If yes, provide date you last reported to work (mm/dd/yyyy) _____
Provide reason:

Are you currently confined to: ☐ bed ☐ house ☐ hospital ☐ not applicable Date of confinement (mm/dd/yyyy) _____
If not confined, describe briefly your daily activities.

Has there been any improvement in your condition? ☐ Yes ☐ No If yes, please describe.

Have you made any attempt to do work since the date of disability began? ☐ Yes ☐ No
If yes, please provide the date you returned to work (mm/dd/yyyy) _____

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 (mm/dd/yyyy) _____

Physicians consulted for this disability:

Name	Hospital/Clinic and Address	Date (mm/dd/yyyy)	Reason/Treatment

Physicians consulted for any condition/illnesses in the past three years:

Name	Diagnosis	Date (mm/dd/yyyy)	Treatment

Are you claiming from any other insurance company in respect to this disability? ☐ Yes ☐ No
If yes, provide details:

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
(Total and Permanent Disability Claim)

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? _____ What's the occupation of the insured? _____

Date of first consultation (mm/dd/yyyy) _____ Date of last consultation (mm/dd/yyyy) _____

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

Other physicians to your knowledge who attended the claimant:

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

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

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

What is the diagnosis? Describe the full and exact diagnosis of the condition causing the total and permanent disability.

Date of Diagnosis (mm/dd/yyyy) _____

Provide details of where the diagnosis was first made:

Name of Doctor	Hospital/Clinic and Address	Date of First Consultation (mm/dd/yyyy)	Telephone Number

Date when patient was first made aware of the diagnosis (mm/dd/yyyy) _____

Is the disability due to an accident? ☐ Yes ☐ No

If yes, provide date and time of the accident (mm/dd/yyyy) _____ Time _____

Details of accident and Injuries of the insured:

Patient's Condition

Describe the nature and severity of the patient's current disability _____

Is the patient confined to a home, hospital or similar institution that provides constant care and medical attention? ☐ Yes ☐ No

What's the current patient's range/capacity of movement? _____

Does the patient have full control of all limbs? ☐ Yes ☐ No

If no, which limb/s does not have full control and the corresponding muscle power? _____

What is the likelihood of improvement in motor function over time? ☐ Very likely ☐ Likely ☐ Not likely

Provide details with respect to the patient's mental abilities and cognition:

Describe the past and current treatment provided, including any operations performed and whether it is likely to improve the patient's condition.

Is the patient compliant with the recommended treatment program? ☐ Yes ☐ No If no, provide details:

What other treatment/s planned for the future? _____

How often is the patient's follow-up check-up for this condition? _____

List all patient's pre-disability major duties relative to his/her occupation:

Duties	Percentage of time spent per day (%)

List all duties that the patient unable to do due to the disability relative to his/her occupation:

Duties	Percentage of time spent per day (%)

Is the patient able to perform all the normal duties of his/her current condition? ☐ Yes ☐ No

If yes, when will the patient be able to return to work? (mm/dd/yyyy) _____

If no, when did he/she cease all work: (mm/dd/yyyy) _____

Can the patient still seek other employment or occupation including voluntary employment? ☐ Yes ☐ No

If yes, what type of work/occupation can the patient engage in? _____

When can he/she engage in these occupations: (mm/dd/yyyy) _____

In your opinion, is the patient totally and permanently disabled as a result of an injury or disease and is unable to engage in any occupation or perform any work for income or profit currently or anytime thereafter? ☐ Yes ☐ No

If yes, when did it commence (mm/dd/yyyy) _____

Is the disability due to total and irrecoverable loss of sight on both eyes? ☐ Yes ☐ No

Is the disability due to loss by severance of two limbs at or above the wrist or ankle? ☐ Yes ☐ No

Is the disability due to total and irrecoverable loss of sight on one eye and loss by severance of the limb at or above the wrist or ankle? ☐ Yes ☐ No

Provide details:

Is the disability due to any self-inflicted act or attempt to suicide? ☐Yes ☐No
Provide details:

Is the disability related to the patient being under the influence of alcohol or any drug?
☐Yes ☐No
Provide details:

Is the disability due to any mental and nervous disorder? ☐Yes ☐No
Provide details:

Is full recovery expected? ☐Yes ☐No
If yes, provide the expected date of recovery (mm/dd/yyyy) _____
If no, provide prognosis of the patient's condition:

Medical History

Did the patient previously suffer from any related illness/es that caused the present condition? ☐Yes ☐No
If yes, provide details:

Is there anything in the patient's medical history which would have increased the risk of the condition? ☐Yes ☐No
If yes, provide details:

Is there a family history of this condition? ☐Yes ☐No
If yes, please provide information such as relationship to insured, nature of illness, date of diagnosis and source of information:

Does the patient have or ever had other significant health conditions? ☐Yes ☐No

Other physicians to your knowledge who attended the patient in relation to Medical History:

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

Provide any other additional information including specialist or hospital records, test results and reports 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 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)
Financial Advisor/Witness Signature over Printed Name	FA Code	Date (mm/dd/yyyy)