Manulife | Chinabank

LIFE ASSURANCE 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: (1800) 1 888 6268
Website: www.manulife-chinabank.com.ph
Email: phcustomercare@manulife.com

Health Insurance Reimbursement Claim Form

Please answer completely and accurately and use black ink. Please countersign on any corrections or erasures. In this form, "the Company" means Manulife China Bank Life Assurance Corporation.

IMPORTANT: Form should be completed by the Policyowner and the Insured. If the Insured is under 18 years old, the parent/guardian should complete this Form on behalf of the insured. Please attach the required documents upon submission.

General Information

Policyowner's Information

Policy Number	Email Address	Mobile Number +63
Policyowner's Last Name	Policyowner's First Name	Policyowner's Middle Name ☐ Do not know/ not applicable

Insured's Information

Insured's Last Name	Insured's First Name	Insured's Middle Name ☐ Do not know/ not applicable

Health Card Account/ ID No. _____

Claim Information

☐ My reimbursement is related to an Inpatient/Hospital Confinement and/or Pre- and Post-confinement benefits.

I was admitted on: _____

I was discharged on: _____

Final Diagnosis: _____

☐ My reimbursement is related to an outpatient procedure or Emergency Room treatment.

Date of Treatment: _____

Final Diagnosis: _____

Hospital Information

Name of Hospital: _____

Address of Hospital: _____

Contact number of Hospital: _____

Physician's Information (Include all who attended to the insured)

Name of Physician	Hospital	Contact No.	Specialization

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Credit to Account Details (Claims payout will be credited to the account of the Policyowner)

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

Currency: ☐ PHP

Account No. _____ Account Name _____

- Please make sure that your bank account details are updated and accurate to avoid unnecessary delay in funds disbursement.
- Kindly submit proof of bank account ownership of the Policyowner.
- Charges may apply for other banks.

Please submit this form together with the following requirements:

Inpatient/ Hospital Confinement

- ☐ Original sales invoice or official receipt/s from the medical facility/ies and/or physician/s
- ☐ Final Statement of Account with itemized billing
- ☐ Discharge summary/discharge instruction
- ☐ Incident/ Police Report (for accident-related treatments and confinements)
- ☐ Photo-bearing, unexpired, clear copy of a government-issued ID of the Policyowner and the Insured
- ☐ Proof of bank account ownership stated in the Credit to Account Details above
  (e.g., deposit slip or screenshot of the bank account number with the name of the bank and Policyowner)
- ☐ Attending Physician's Statement

Outpatient Treatment (for covered procedures and pre- and post-confinement treatments)

- ☐ Original sales invoice or official receipt/s from the medical facility/ies and/or physician/s
- ☐ Physician's order
- ☐ Incident/ Police Report (for accident-related treatments and confinements)
- ☐ Laboratory/diagnostic tests
- ☐ Physician's prescription for medicines (for pre- and post-confinement treatments)
- ☐ Photo-bearing, unexpired, clear copy of a government-issued ID of the Policyowner and the Insured
- ☐ Proof of bank account ownership stated in the Credit to Account Details above
  (e.g., deposit slip or screenshot of the bank account number with the name of the bank and Policyowner)
- ☐ Attending Physician's Statement for covered special procedures

Emergency Treatment

- ☐ Original sales invoice or official receipt/s from the medical facility/ies and/or physician/s
- ☐ Incident/ Police Report (for accident-related treatments and confinements)
- ☐ Emergency Room Report
- ☐ Photo-bearing, unexpired, clear copy of a government-issued ID of the Policyowner and the Insured
- ☐ Proof of bank account ownership stated in the Credit to Account Details above
  (e.g., deposit slip or screenshot of the bank account number with the name of the bank and Policyowner)

Notes:

1. This Form with the complete information and all supporting documents must be submitted to the Company within the 90 days from date of treatment/last day of confinement.
2. Claims will only be processed upon submission of complete requirements.
3. The Company may contact you or the insured for additional information and/or documents to complete the assessment of your claims.
4. Please ensure that the original receipts are stored securely and remain accessible within six (6) months from the date of submission, should they be needed for any follow-up inquiries or auditing processes.

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Declaration and Agreement

I, the Policyowner, personally and on behalf of the Insured in this Health Insurance Claim Form ("Form"), confirm that the answers and statements herein and other documents attached are complete, accurate, and true according to my personal knowledge and based on official records. By signing this Form and/or continuing to avail of Company's products and services, I also understand, declare, warrant, and agree to the following:

1. I have carefully read, understood, and agree with all the instructions and questions that are written in the Form. Notices related to my claim shall be sent to me through the contact details I provided above. I allow the Company to update our records based on the information found in this Form and to use such to administer and service the policy.
2. Submission of this Form and other documents required by the Company does not constitute an admission that there is any insurance in force nor any liability for payment of the benefits provided in the Policy. Completion of this Form does not automatically guarantee the approval of my claim.
3. I authorize and provide consent for any physician, medical practitioner, hospital, clinic, other medical or medically related facility, or healthcare and medical services provider, record custodian, medical secretary, insurance or reinsurance company, the industry association database or the Medical Information Database created under IC CL No. 2016-54, consumer reporting agency, any entity or employer having information relevant to the completion and processing of this claim (collectively, "Healthcare Provider") to give the Company or its duly authorized representatives, without restriction, any and all such information.
4. A photographic copy or other reproduction of this Form with the authorization provided herein shall be sufficient, valid, and effective, and therefore should be accepted as the original copy. This authorization discharges the Healthcare Provider or any of its authorized member or staff from any responsibility or obligation in connection with the release and disclosure of such record or information. Any prior or existing right or agreement to privacy is deemed waived and not applicable for this authorization.
5. In accordance with the Insurance Commission's (IC) Circular Letter No. 2016-54, as may be amended from time to time, the medical information of the Insured will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to the information in line with the right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the Insurance Commission's website at www.insurance.gov.ph.
6. Upon receipt of the proceeds of this claim, 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 representatives 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 and 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 fully answer all costs and expenses, including attorney's fees, interests, 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.
7. The deposit of the proceeds to the aforementioned bank account shall be equivalent to payment to me directly of the same. I take full responsibility in the accuracy of the bank account details above and should there be any error/s in the information, I understand that this will result to delays, among others, and I shall solely bear the consequences.
8. 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.
9. The Company collects and uses my personal data to operate an insurance business. The information I provided (including the information of third parties) and any subsequent changes to it can be processed 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) for purposes of administering and servicing my policy and for other purposes as stated in the Company's privacy policy and notice available at www.manulife-chinabank.com.ph/Customer-Privacy-Policy, in accordance with the Data Privacy Act of 2012, as may be amended from time to time, relevant regulations and the Company's privacy policy and notice.
10. 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.
11. I have read and fully understand the foregoing statements and I voluntarily executed this Form including the release, waiver and quitclaim as my own free act and deed without any duress or intimidation on the part of any person.

Policyowner's Signature over Printed Name	Date Signed (mm/dd/yyyy)	Place Signed