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

Dear Mr. / Ms. _____ :

We are sorry to learn of your injury.

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

1. Accident Claim Form
2. Attending Physician's Statement
3. Statement from Identifying Witness, if applicable
4. Police or NBI Report, if applicable
5. Medical Abstract / Admitting History, if applicable
6. Operation Room Record, if applicable
7. Valid Identification Document

Upon receipt of the applicable above stated 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.

Attached are the Accident 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. Please continue to pay the premiums.

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

Very truly yours,

_____

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Accident Benefit Claim Form

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).

Policy No.

Claim No.

1. PERSONAL PARTICULARS OF POLICYHOLDER

Name _____ Passport/ID No _____

Date of Birth _____ Age _____ Sex _____ Office Telephone No. _____

Address _____ 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. _____

Address _____ Home Telephone No. _____

_____ Mobile No. _____

Present Occupation _____

_____

3. DETAILS OF IINJURY

(a) Date and Place of Accident _____

(b) Describe in details how the accident happened. _____

_____

(c) Describe the injury/ies in details. _____

_____

(d) What was the diagnosis? _____

_____

(e) Date you last worked as a result of the accident _____ Date returned or expect to return to work _____

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 Accident 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 **ACCIDENT BENEFIT CLAIM**. 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 patient first consult you for the injury? _____/_____/_____ (dd / mm / yyyy)

3. What was the cause of the injury? _____

   _____

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

   If yes, please state name & address of hospital _____

   _____

   Complaint/s _____

   _____

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

   Final Diagnosis _____ Prognosis _____

5. In your opinion what were the likely durations of the patient's injury(ies)? Please provide reasons.

   _____

   _____

How do you assess the patient's injury, will he/she be considered as :

☐ Partial/Temporary Disability ☐ Total/Permanent Disability

Start of disability _____ To _____

When is the patient expected to return to his/her usual occupation or employment? _____

6. If Surgical Procedure was performed, please describe in details and provide copy of the Operation Room Record.

_____

_____

7. Assessment of the patient's condition. (Please provide complications/results of treatment of the injury(ies)

_____

_____

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.