

Dear Mr. / Ms. \_\_\_\_\_ :

We are sorry to learn of your illness/injury.

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

1. Health Benefit Claim Form / Attending Physician's Statement
2. Copy of your Valid Identification Document or Passport
3. All available laboratory and tests results
4. Medical Abstract / Admitting History
5. Applicable Receipts (e.g. outpatient consultation & ambulance service fees)
6. Detailed Statement of Account

Upon receipt of **ALL** the above 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.

**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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**3. RECORD OF MEDICAL CONSULTATIONS**

Please provide the names of the doctors you had consulted in relation to your illness(es) and the addresses of their respective hospitals / clinics and dates of consultation.

Name of Doctor	Name / Address of Hospital / Clinic	Dates of First Consultation

Details of the names(s) and address(es) of the doctor(s) you see most of the time when you are sick.

Name of Doctor	Address	Telephone No. / Fax No.

**4. GENERAL**

Have any of your blood relatives suffered from a similar or related illness?  Yes  No  
If "yes", please provide the following details.

Relationship of Relative	Nature of Illness	Date Illness First Diagnosed

Do you smoke?  Yes  No

If "Yes", please provide the following information.

(i) How many cigarettes do you smoke per day? \_\_\_\_\_

(ii) For how long have you been smoking? \_\_\_\_\_

Do you consume alcohol?

If "Yes", please provide the following information.  Yes  No

(i) Type of alcohol \_\_\_\_\_

(ii) Quantity consumed per day \_\_\_\_\_

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## 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**



If yes, please provide details below.

Name of Doctor	Name of Clinic/ Hospital and Address

5. Was the service of an ambulance used for the patient's hospital confinement?  Yes  No

If yes, this must be supported by an official receipt for use of an ambulance.

6. Was the patient admitted in the hospital?  Yes  No

If yes, please state name and address of hospital \_\_\_\_\_

Complaint/s \_\_\_\_\_

Date of Admission \_\_\_\_\_ Date of Discharge \_\_\_\_\_ No. of Days \_\_\_\_\_

Was patient given care at the ICU?  Yes  No

If yes, please state dates of ICU confinement: From \_\_\_\_\_ To \_\_\_\_\_ No. of Days \_\_\_\_\_  
(must be supported with a hospital billing statement)

Final Diagnosis \_\_\_\_\_ Prognosis \_\_\_\_\_

7. Were there prescription drugs during the patient's hospital confinement?  Yes  No

If yes, this must be supported with the details/copy of drugs prescribed in the hospital billing statement.

8. Is there any Surgical Procedure Performed?  Yes  No

If yes, please describe the surgical procedure performed in details and attach copy of Pathology Result and copy of Operation Room Record.

\_\_\_\_\_

\_\_\_\_\_

Please state Name of Surgeon \_\_\_\_\_ Date of Surgery Performed \_\_\_\_\_

9. Was treatment as an outpatient required for the following?

Kidney Dialysis  Yes  No

Cancer Treatment  Yes  No

Stroke Treatment  Yes  No

If yes, please provide details/manner of treatment.

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10. To the best of my knowledge, do you consider her to be **TOTALLY DISABLED** (unable to work)  Yes  No

If yes, please provide period of Total Disability

From \_\_\_\_\_ To \_\_\_\_\_

Or give approximate date when she would be able to return to work \_\_\_\_\_

11. Please provide any other information that have a bearing to this claim.

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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)

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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.