Manulife

Accident Claim Checklist

- ☐ **CLAIMANT'S STATEMENT (GROUP ACCIDENT BENEFIT) FORM**
- ☐ **ATTENDING PHYSICIAN'S STATEMENT (GROUP ACCIDENT BENEFIT) FORM**
- ☐ **EMPLOYER'S STATEMENT or POLICYHOLDER'S STATEMENT** - *This form is provided by the Company and to be filled out by the Employer's Authorized Representative or the Association/Organization's authorized representative (Requirement shall not be applicable for Group Credit Life – GCL accounts)*
- ☐ **ORIGINAL COPY OF OFFICIAL RECEIPT**
- ☐ **ORIGINAL COPY OF STATEMENT OF ACCOUNT**
- ☐ **ORIGINAL OR CERTIFIED TRUE COPY OF BIRTH** - *if insured is a Minor*
- ☐ **PHOTOCOPY OF TWO (2) VALID/GOV'T ISSUED IDs OF INSURED'S PARENT** - *if insured is a Minor*
- ☐ **STATEMENT FROM IDENTIFYING WITNESS** (*if applicable*)
- ☐ **POLICE or NBI REPORT** (*if applicable*)
- ☐ **MEDICAL ABSTRACT / ADMITTING HISTORY** (*if applicable*)
- ☐ **OPERATION ROOM RECORD** (*if applicable*)

Reminders:

- *Any documents issued abroad must be duly authenticated by the Philippine Consulate in the state where the documents originated. Additional claim documents may be required, as necessary.*
- *To ensure timely release of the claim benefit, please ensure accuracy & completeness of all required information in the forms and that all documents/requirements are submitted.*
- *If insured is a minor, benefit settlement shall be made payable to any of the insured's parents. If insured is under the custody of a guardian, an Affidavit of Substitute Parental Care and Custody shall be required.*

Manulife

The Manufacturers Life Insurance Co. (Phils.), Inc.
Head Office: 10th Floor NEX Tower, 6786 Ayala Avenue, Makati City, 1229, Philippines
Customer Care: (02) 884-7000
Domestic Toll-Free: 1-800-1-888-6268
Website: www.manulife.com.ph
Email:phcustomercare@manulife.com

Claimant's Statement
(Group Accident Benefit)

Please print clearly. Use black ink.

Claimant's Information

Policy Number/s	Name of Life Insured (Last, First, MI)

Mailing Address (Number, Street, Apartment/Suite No., Barangay/Town, Municipality/City, State, Country, ZIP Code)

Mobile Number (Country Code + Area Code + Telephone Number)	Email Address

Details of Claim

Date of Accident (mm/dd/yyyy) _____ Place Of Accident _____

Describe in details how the accident happened

Describe the extent of the injury/ies

What was the diagnosis?

Date you last worked as a result of the accident: _____ (mm/dd/yyyy)

Date returned or expected to return to work: _____ (mm/dd/yyyy)

Declarations and Authorization

I hereby certify that the above statements are true and complete to the best of my knowledge and belief.

I authorize Manulife and/or its duly authorized representatives to request and secure any or all information, records or documents which are available from any medical practitioner, government or private hospital/clinic, medical offices or clinics in relation to the processing of the accident benefit claim. I agree that a photographic copy of this authorization shall be valid as the original. This also discharges any such physician, medical practitioner, hospital clinic, medical office or facility and all members of its staff from any liability or obligation by reason of the release of such information/document/records.

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.

_____ _____
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 Accident Benefit)

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) _____

What was the cause of the injury? _____

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

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

Date of Discharge (mm/dd/yyyy) _____

Diagnosis _____

How long would it take for the insured to recover? _____

Prognosis _____

Is there any surgical procedure performed? ☐ Yes ☐ No

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

What is your assessment of the patient's condition? Please include results of and complication/s (if any) from the treatment of the injury.

Date the insured last reported to work as a result of the accident (mm/dd/yyyy) _____

Date the insured returned or is expected to return to work (mm/dd/yyyy) _____

How do you assess the insured's injury? Choose one below.

- ☐ a. Total Permanent Disability (If the insured is prevented from engaging in any gainful occupation for which he is or becomes reasonably fitted by education, training or experience)
- ☐ b. Temporary Total Disability (If the insured is prevented from performing all duties pertaining to his occupation)
- ☐ c. Temporary Partial Disablement (If the insured is prevented from performing one or more duties pertaining to his occupation)
- ☐ d. Hospital Indemnity (If the ensured is admitted to a licensed hospital as a result of an accident)

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 representative 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)	Place Signed

Financial Adviser/Witness Signature over Printed Name	FA Code	Date (mm/dd/yyyy)

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Employer's Statement Form

Employer/Policyholder
Policy Number

Insured/Employee Information

Name (Last, First, Middle)		Position/Title
Date Hired (mm/dd/yyyy)	Regularization Date (mm/dd/yyyy)	Separation Date (mm/dd/yyyy) if applicable
Date last reported to work (mm/dd/yyyy)	Employee was on leave prior to date of event? ☐ Yes ☐ No If yes, indicate reason: _____	

Coverage Data

Type of Claim:			Date of Event (mm/dd/yyyy)
☐ Death	☐ Disability	☐ Critical/Terminal Illness	
☐ Accident	☐ Hospitalization		Claim Amount*

*Please refer to your Group Master Policy Contract, Policy Specification Page - schedule of insurance benefits

Declarations and Authorization

I do hereby certify the truth and correctness of the above information in my capacity as the authorized representative of the Employer/Policyholder to support the claim of the Group Insurance Benefit.

_____
Signature over Printed Name of Authorized Representative

_____ _____ _____
Position/Title Date Signed (mm/dd/yyyy) Place Signed

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Policyholder's Statement Form

Policyholder
Policy Number

Insured/Member's Information

Name (Last, First, Middle)	Position/Title
Membership Start Date (mm/dd/yyyy)	Separation Date (mm/dd/yyyy) if applicable

Has the membership been suspended? ☐ Yes ☐ No

If yes, indicate reason: _____ Date of Reinstatement (mm/dd/yyyy) _____

Coverage Data

Type of Claim:

☐ Death ☐ Disability ☐ Critical/Terminal Illness

☐ Accident ☐ Hospitalization

Date of Event (mm/dd/yyyy)

Claim Amount*

*Please refer to your Group Master Policy Contract, Policy Specification Page - schedule of insurance benefits

Declarations and Authorization

I do hereby certify the truth and correctness of the above information in my capacity as the authorized representative of the Organization/Policyholder to support the claim of the Group Insurance Benefit.

_____
Signature over Printed Name of Authorized Representative

_____ _____ _____
Position/Title Date Signed (mm/dd/yyyy) Place Signed