Manulife

The Manufacturers Life Insurance Co. (Phils.), Inc.
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Attending Physician's Statement
(Group Death Claim)

Physician's Information

Policy Number	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

Full Name of Deceased (Last, First, Middle)

Date of Death (mm/dd/yyyy)	Place of Death	Cause of Death

Cause of Death

☐ A. Decease or condition directly leading to death
☐ B. Antecedent causes (morbid conditions, if any giving the rise to the above cause)
Due to _____
☐ C. Other significant conditions (contributing to the death but not related to the disease or condition causing death)

Is the death due to accident, suicide or homicide? ☐ Yes ☐ No
If yes, specify and describe briefly:

Was the deceased under the influence of liquor/drugs when the accident/suicide/homicide happened? ☐ Yes ☐ No
Was there an official inquiry as to cause of death or a post-mortem examination on the body of the deceased? ☐ Yes ☐ No
If Yes, please provide the official report.
Have you seen the corpse of the Deceased? ☐ Yes ☐ No
How long have you known the deceased? _____ What were the symptoms first noticed by deceased? _____
What was your diagnosis?

Were you able to inform the deceased of your diagnosis? ☐ Yes ☐ No How long did the deceased suffered from the ailment? _____

Physicians to your knowledge who attended the deceased for any illness:

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

Condition and Illnesses to your knowledge you treated the deceased in the past three years:

Symptoms	Diagnosis	Date (mm/dd/yyyy)	Treatment

Other hospitals/clinics to your knowledge where the deceased was treated:

Hospital/Clinic	Address	Date (mm/dd/yyyy)	Diagnosis

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 Deceased (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)