Manulife

The Manufacturers Life Insurance Co. (Phils.), Inc.
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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