Manulife

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