Manulife

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ATTENDING PHYSICIAN'S STATEMENT (Female Benefit)

CLAIMANT'S NAME (Last, First, MI)	
ATTENDING PHYSICIAN'S NAME	ADDRESS

This section must be completed by a qualified and registered physician at the expense of the claimant.

The above name is insured with us against the happening of certain contingent events associated with her health. A claim has been submitted in connection with **FEMALE BENEFIT.** To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

GENERAL INFORMATION

1. Are you the claimant's usual medical doctor? ☐ Yes ☐ No
If yes, over what period do your records extend to?
Start Date (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐ End Date (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

2. When did the claimant first consult you for this condition? (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

3. Please state symptoms presented and date symptoms first appeared.

SYMPTOMS PRESENTED AT FIRST CONSULTATION	DATE SYMPTOMS FIRST STARTED (MM/DD/YYYY)
	☐☐/☐☐/☐☐☐☐
	☐☐/☐☐/☐☐☐☐
	☐☐/☐☐/☐☐☐☐

What / Who is the source of this information? _____

4. In your opinion what were the likely durations of the claimant's symptoms? Please provide reasons.

_____

_____

5. Did the claimant consult any other doctors for these symptoms before she consulted you? ☐ Yes ☐ No If yes, please provide the details below.

NAME OF DOCTOR	NAME / ADDRESS OF HOSPITAL / CLINIC

6. Please provide the details below when she consulted you.

DATES ATTENDED	COMPLAINTS & PHYSICAL EXAMINATION FINDINGS	DURATION OF ILLNESS	DIAGNOSIS	DESCRIBE TREATMENT/ PROCEDURE

7. Has she been admitted in the hospital? ☐ Yes ☐ No

If yes, please state name of hospital/address

Complaint(s)

Date of Admission (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐ Time Admitted _____

Date of Discharge (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐ Time Discharged _____

Diagnosis

Prognosis

If admission is due to Maternity related condition, please provide the following information.

Date of Delivery (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐ Number of Delivery ☐☐

Is there finding of any Pregnancy Complication? ☐ Yes ☐ No

If yes, please describe finding in details. (Please provide copies of test result/s)

_____

_____

Is there finding of any Congenital Anomaly? ☐ Yes ☐ No

If yes, please describe finding in details. (Please provide copies of test result/s)

_____

_____

8. Is there any Surgical Procedure Performed? ☐ Yes ☐ No

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

_____

_____

9. Assessment of her present condition (Please include sequelae/complications/results of treatment of the illness/es).

_____

_____

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

If yes, please provide period of Total Disability From ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY) To ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY)

Or give approximate date when she would be able to return to work ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY)

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

_____

_____

ATTENDING PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

Contact Number(s)

To the Attending Physician: You may use additional sheets if more space is needed for the above information requested. You may also submit this form directly to any Manulife Office nationwide.