Manulife

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ATTENDING PHYSICIAN'S STATEMENT (Hospital Income 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 hislher health. A claim has been submitted in connection with **HOSPITAL INCOME BENEFIT.** To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

GENERAL INFORMATION

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) ☐☐/☐☐/☐☐☐☐

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

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? _____

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

_____

_____

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

NAME OF DOCTOR	NAME / ADDRESS OF HOSPITAL / CLINIC

Please provide the details below when he/she consulted you.

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

Was the service of an ambulance used for the patient's hospital confinement? ☐ Yes ☐ No If yes, this must be supported by an official receipt for use of an ambulance.

Was the patient 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 _____

Was patient given care at the ICU? ☐ Yes ☐ No

If yes, please state dates of ICU confinement (must be supported with a hospital billing statement): From _____ to _____ No. of days _____

Final Diagnosis	Prognosis

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

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.