Manulife

ATTENDING PHYSICIAN'S STATEMENT MAJOR DISEASE/CRITICAL ILLNESS LOSS OF LIMBS

Name

Policy Number/s

Claim Number

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 his/her health. A claim has been submitted in connection with **LOSS OF LIMBS.** To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

A. GENERAL INFORMATION

1. Are you the patient's usual medical doctor? ☐ Yes ☐ No

   If yes, over what period do your records extend to?

   Start date _____ / _____ / _____ End date _____ / _____ / _____
   dd mm yyyy dd mm yyyy

2. When did the patient first consult you for this condition? _____ / _____ / _____
   dd mm yyyy

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

Symptoms Presented at First Consultation	Date Symptoms First Started (DD/MM/YYYY)

   What / Who is the source of this information? _____

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

   _____

   _____

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

Name of Doctor	Name of Clinic/ Hospital and Address

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B. DETAILS OF MAJOR DISEASE / CRITICAL ILNESS

6. (a) What is the diagnosis? Please provide full details of the diagnosis. _____

_____

_____

(b) Date of diagnosis _____ / _____ / _____
dd mm yyyy

(c) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.

Name of Doctor	Name of Clinic/ Hospital and Address

(d) Date when patient was first made aware of the diagnosis? _____ / _____ / _____
dd mm yyyy

(e) Was the patient admitted in the hospital? ☐ Yes ☐ No

If yes, please state name & address of hospital _____

_____

Complaint/s _____

Date of Admission _____ Time _____ Date of Discharge _____ Time _____
Admitted Discharged

7. Please describe the extent of the severance due t o Loss of Limbs.

(a) Date of onset _____ / _____ / _____
dd mm yyyy

(b) Number of limbs involved :

(c) Which limbs are involved :

(d) Is there total and irreversible loss of use of the involved limbs? ☐ Yes ☐ No

If yes, please provide basis for prognosis.

(e) Is the total and irreversible severance above the wrist or ankle? ☐ Yes ☐ No

(f) Did the paralysis result from a self-inflicted act? ☐ Yes ☐ No

If yes, please give full details.

8. Please provide details of current treatment provided.

9. What is the prognosis?

10. Please provide full details of tests and results which have been performed to establish the diagnosis of Loss of Limbs, and attach copies of all relevant hospital reports, laboratory and test results, including neurological reports, CT scans, MRI and other imaging studies and surgical reports.

11. Please provide the names and addresses of all clinics/hospitals to which the patient has been referred to or attended for this condition together with the names of doctors consulted.

Name of Doctor	Name of Clinic/ Hospital and Address

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C. MEDICAL HISTORY

12. Has the patient previously suffered from the condition specified above or any related illnesses? ☐ Yes ☐ No

    If yes, please provide details including dates of consultations, their resulting diagnosis, the name and address of attending. Please state source of information._____

Date of Consultation	Name of Doctor / Address	Diagnosis

13. Is there anything in the patient's medical history which would have increased the risk of Loss of Limbs?

    ☐ Yes ☐ No

    If yes, please provide details including the dates of consultations and their resulting diagnosis, name and address of attending doctor. Please state source of information. _____

Date of Consultation	Name of Doctor / Address	Diagnosis

14. Please give details of the patient's family history which would have increased the risk of Loss of Limbs (including the relationship, nature of illness, date of diagnosis) Please state source of information. _____

    _____

    _____

15. Please give details of the patient's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day. Please state source of information. _____

    _____

    _____

16. Please give details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day. Please state source of information. _____

    _____

    _____

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17. Does the patient have or ever had any other significant health condition(s)? ☐ Yes ☐ No

If yes, please provide details of the condition, including diagnosis, date of diagnosis, duration of condition(s) and treatment received.

_____

_____

_____

D. ADDITIONAL INFORMATION

18. Please provide us with any other additional information that will enable the Company to assess this claim.

_____

_____

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	**Telephone Number (s)**

To the Attending Physician : You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.