Manulife China Bank
LIFE ASSURANCE CORPORATION
a joint venture between Manulife Philippines and China Banking Corporation

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Attending Physician's Statement
Disability Claim

Notes:
1. Please return the completed Attending Physician's Statement to Manulife Philippines.
2. This section must be completed by a qualified and registered physician at the expense of the insured.

1. PATIENT'S PARTICULARS

Name of Patient _____ Date of Birth _____ Age _____

Occupation _____

2. CONSULTATION FOR PRESENT ILLNESS/INJURY (IES)

(a) Date of first consultation with you _____ / _____ / _____
dd mm yyyy

(b) Date of last consultation with you _____ / _____ / _____
dd mm yyyy

(c) Please state the symptoms presented and the date symptoms first appeared.

Symptoms Presented at First Consultation	Date of Consultations (DD/MM/YY)

(d) What is the source of this information? _____

If "Others", please specify _____

(e) What was the diagnosis? _____

(f) Diagnosis was first made by (name of doctor) _____

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

(h) Date of diagnosis was made known to the patient _____ / _____ / _____
dd mm yyyy

(i) If the condition was a result of an accident, please provide the following information:

(i) Date of accident _____ / _____ / _____
dd mm yyyy

(ii) Please describe in detail how the accident happened.

_____

_____

(iii) Please describe the injuries suffered by the patient.

_____

_____

3. PATIENT'S CONDITION

(a) Please describe fully the nature and severity of the patient's current disability.

_____

_____

(b) Is the patient confined to a home, hospital or similar institution that provides constant care and medical attention? ☐ Yes ☐ No

(c) Please comment on the patient's range of movement.

_____

_____

(d) Does the patient have full power of all limbs? ☐ Yes ☐ No

If no, please state which limb(s) do(es) not have full power and the corresponding muscle power?

_____

_____

(e) What is the likelihood of improvement in motor function over time?

_____

_____

(f) What is the likelihood of improvement in motor function over time?

_____

_____

(g) Please provide full details with respect to the patient's mental abilities and cognition.

_____

_____

(h) Please describe the past and current treatment provided, including any operations performed and whether it is likely to improve his/her condition.

_____

_____

(i) Is the patient compliant with the recommended treatment program? ☐ Yes ☐ No
If no, please elaborate.

_____

_____

(j) What treatment is planned for the future?

_____

_____

(k) How often must the patient be on follow-up for this condition?

_____

_____

(l) Please provide all duties of the patient's usual occupation, including percentage of time spent in each.

Duties	Percentage%
_____	_____
_____	_____

(m) Please provide full details of the patient's capabilities and limitations in relation to his/her usual occupation.

Capabilities (What the patient can do)

_____

_____

Limitations (What the patient cannot do)

_____

_____

(n) Is the patient able to perform all the normal duties of his/her usual condition?

☐ Yes ☐ No

If yes, when is he/she expected to return to his usual occupation.

_____ / _____ / _____
dd mm yyyy

If no, when did he/she cease all work. _____ / _____ / _____
dd mm yyyy

(o) If the patient is unable to return to his/her usual occupation, is he/she able to engage in any occupation? ☐ Yes ☐ No

If yes, please provide us with the following details.

(i) What type of occupation can he/she engage in?

_____

_____

(ii) When is he/she expected to engage in these occupations?

_____ / _____ / _____
dd mm yyyy

(p) In your opinion, is the patient **totally and permanently disabled** as a result of bodily injury or disease and is **unable to engage in <u>any</u> occupation** or whatsoever **or perform any work for income or profit** currently or at anytime thereafter. ☐ Yes ☐ No

If yes, when did such commence. _____ / _____ / _____
dd mm yyyy

(q) Is the disability due to the occurrence of any of the following:

(i) Total and irrecoverable loss of sight of both eyes ☐ Yes ☐ No

(ii) Loss by severance of two limbs at or above the wrist or ankle ☐ Yes ☐ No

(iii) Total and irrecoverable loss of sight of one eye and loss by severance of one limb at or above the wrist or ankle. ☐ Yes ☐ No

If you have ticked any of the above boxes, please provide details.

_____

_____

(r) Did the disability arise due to any of the following:

(i) Any self-inflicted act or attempt at suicide ☐ Yes ☐ No

(ii) The patient being under the influence of any alcohol/drug ☐ Yes ☐ No

(iii) Any mental or nervous disorder ☐ Yes ☐ No

If you have ticked any of the above boxes, please provide details.

_____

_____

(s) Is full recovery expected? ☐ Yes ☐ No

If yes, please state the expected recovery date. _____ / _____ / _____
dd mm yyyy

If no, please state the prognosis of the patient's condition. _____

4. MEDICAL HISTORY

(a) Did the patient previously suffer from any related illness(es) that caused the present condition?
☐ Yes ☐ No
If yes, please provide details.

_____

_____

(b) Is there a family history of this condition? ☐ Yes ☐ No

If yes, please provide information such as relationship to insured, nature of illness, date of diagnosis and source of information.

_____

_____

(c) Did the patient consult other doctors for this illness or its symptoms before he/she consulted you?
Yes ☐ No ☐

If yes, please provide the name(s) and addresses(es) of the doctor(s) who he/she consulted.

Name of Doctor	Name and Address of Clinic/Hospital	Consultation Dates

(d) Is the patient suffering or has suffered from any other significant illnesses?
☐ Yes ☐ No

If yes, please provide the following information to us:

Name of Doctor	Name and Address of Clinic/Hospital	Diagnosis Date and Illness

(e) Please give any other information, which you feel would be helpful in assessment of the patient's claim.

_____

_____

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the patient's claim.

I hereby certify that the above statements are true and complete to the best of my knowledge and belief.

Signature Over Printed Name of Physician	**Date Signed**
Qualification	**Address**
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.