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

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Attending Physician's Statement Major Disease/Critical Illness Encephalitis

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 **Encephalitis**. 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 _____ / _____ / _____ (dd / mm / yyyy) End date _____ / _____ / _____ (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

   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

B. DETAILS OF MAJOR DISEASE / CRITICAL ILLNESS

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 initial episode.

(a) Nature of episode _____

(b) Date of initial episode _____ / _____ / _____
dd mm yyyy

(c) Duration of acute symptoms _____

(d) Is the patient able to return to normal activities? ☐ Yes ☐ No

If yes, please state when _____ / _____ / _____
dd mm yyyy

If no, please state the patient's current physical and mental limitations.

8. (a) How long has the patient's neurological damage lasted since the initial episode? Please provide duration in hours / days weeks.

   (b) Please provide description of the neurological damage.

   (c) Is this neurological damage permanent? ☐ Yes ☐ No

   (e) Has there been inflammation of the brain in the cerebral hemisphere, brainstem or cerebellum? ☐ Yes ☐ No

   (f) Is the inflammation associated with viral or bacterial infections? ☐ Yes ☐ No

   (g) Is this inflammation resulted from parasitic infections such as malaria? ☐ Yes ☐ No

9. Please provide details of all investigations/test performed and enclose copies of all reports, e.g. CT scan and MRI scan reports, other imaging studies, laboratory evidence, and other relevant hospital reports.

10. Are the investigation findings consistent with the diagnosis of Encephalitis? ☐ Yes ☐ No

    If yes, please give details.

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 the doctors consulted.

Name of Doctor	Name of Clinic/ Hospital and Address

12. Has the patient previously suffered from stroke or any related illnesses (e.g. hypertension, transient ischemic attack, angina and other cardiovascular diseases? ☐ Yes ☐ No

    If yes, please provide details.

    _____

    _____

13. Is there anything in the patient's medical history which would have increased the risk of Encephalitis? ☐ Yes ☐ No

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

    _____

    _____

14. Please give details of the patient's family history which would have increased the risk of having Encephalitis (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. _____

    _____

    _____

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.

    _____

    _____

18. Is the brain damage due to Transient Ischemic Attack? ☐ Yes ☐ No
If yes, please provide details.

19. Is the brain damage due to an accident or injury? ☐ Yes ☐ No

If yes, please provide details.

E. ADDITIONAL INFORMATION

20. 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.

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.