

Manulife China Bank Life Assurance Corporation

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Attending Physician's Name

Attending Physician's Head Office: 10th Floor NEX Tower, 6786 Ayala Avenue, Makati City, 1229 Philippines Customer Care: +632 8884-7000 Domestic Toll-Free: 1-800-1-888-6268 Website: www.manulife-chinabank.com.ph **Statement Major Disease** /Critical Illness Fulminant **Viral Hepatitis** Patient's Name

Address

		s to assess th	a with his/her hi	ealth. A claim has ould be grateful for
GENERAL INFORMATION				
Are you the patient's usual medical doctor?	Yes		lo	
f yes, over what period do your records extend to?				
Start date / / / / yyyy	End date	//	mm	уууу
When did the patient first consult you for this condition?				
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?				
n your opinion what were the likely durations of the patient's	s symptoms? Please	e provide rea	sons.	
Did the patient consult any other doctors for these symptoms	s before he/she con	sulted you?	Yes	□ No
f yes, please provide details below.				
Name of Doctor	Name of Clinic/ Hospital and Address			
	f yes, over what period do your records extend to? Start date/	f yes, over what period do your records extend to? Start date/ / End date When did the patient first consult you for this condition? Please state symptoms presented and date symptoms first appeared. Symptoms Presented at First Consultation Date Symptoms What / Who is the source of this information? In your opinion what were the likely durations of the patient's symptoms? Please Did the patient consult any other doctors for these symptoms before he/she configure, please provide details below.	f yes, over what period do your records extend to? Start date / End date / End date / dd When did the patient first consult you for this condition? / dd Please state symptoms presented and date symptoms first appeared. Symptoms Presented at First Consultation Date Symptoms First Starte What / Who is the source of this information? nyour opinion what were the likely durations of the patient's symptoms? Please provide real Did the patient consult any other doctors for these symptoms before he/she consulted you? f yes, please provide details below.	f yes, over what period do your records extend to? Start date / / End date / dd mm When did the patient first consult you for this condition? / dd mm Please state symptoms presented and date symptoms first appeared. Symptoms Presented at First Consultation Date Symptoms First Started (DD/MM/YYY) What / Who is the source of this information? nyour opinion what were the likely durations of the patient's symptoms? Please provide reasons. Did the patient consult any other doctors for these symptoms before he/she consulted you? Yes f yes, please provide details below.

Name of Doctor	Name of Clinic/ Hospital and Address

B. DETAILS OF MAJOR DISEASE / CRITICAL ILLNESS (a) What is the diagnosis? Please provide full details of the diagnosis. (b) Date of diagnosis (c) What is the underlying illness causing Fulminant Viral Hepatitis. (d) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made. Name of Doctor Name of Clinic/Hospital **Address** (e) Date when patient was first made aware of the diagnosis? ☐ No (f) Was the patient admitted in the hospital? Yes If yes, please provide the following details. Name / Address of Hospital Date of Admission ______ Date Discharged ______ No. of Days _____ 7. Please provide details, including dates, of the extent of the patient's disease. (a) Was the patient's illness caused by submassive to massive necrosis of the liver by the Hepatitis virus? Yes

If yes, since when?

Is the illness	leading precipitously to liver failure?	Yes	☐ No	
If yes, since		//		
Is the diagnosis in respect of this illness based on the meeting of all of the following criteria?				
i.	A rapidly decreasing liver size	Yes	☐ No	
ii.	Necrosis involving entire lobules, l Collapsed reticular framework.	leaving only a Yes	☐ No	
iii.	Rapidly deterioration of liver function	ions tests Yes	☐ No	
iv.	Deepening jaundice	☐ Yes	□ No	
Is the liver di	sease resulted from any of the follow	ving?		
i.	Directly or indirectly caused by att	empted suicide? Yes	☐ No	
ii.	Poisoning	☐ Yes	☐ No	
iii.	Drug overdose	☐ Yes	☐ No	
iv.	Excessive alcohol ingestion	☐ Yes	□ No	
ase comment o	on whether the diagnosis was suppo	orted by the following:		
Liver function	test to show massive parenchymal	liver disease. Yes	☐ No	
If yes, please	attach copy of the test and result.			
Objective sig	ns of portasystematic encephalopat	hy. Yes	No	
If yes, please	attach copy of the test and result.	_	_	
at is the progn	osis of the patient and the treatment	plan?		
	If yes, since to the diagnood it. ii. iii. iv. Is the liver distinction it. ii. iv. ase comment of the c	If yes, since when? Is the diagnosis in respect of this illness based of i. A rapidly decreasing liver size ii. Necrosis involving entire lobules, Collapsed reticular framework. iii. Rapidly deterioration of liver functiv. Deepening jaundice Is the liver disease resulted from any of the follow i. Directly or indirectly caused by att ii. Poisoning iii. Drug overdose iv. Excessive alcohol ingestion Excessive alcohol ingestion Asse comment on whether the diagnosis was supported by the signs of portasystematic encephalopate. If yes, please attach copy of the test and result. Objective signs of portasystematic encephalopate if yes, please attach copy of the test and result. As is the prognosis of the patient and the treatment is the prognosis of the patient and the treatment is the provide details of all investigations/tests per oscopy report, histological, radiological reports (If yes, since when? dd	If yes, since when?

Name of Doctor	Name of Clinic/Hospital	Address			
MEDICAL HISTORY					
las the patient previously suffered from Fulminant Viral Hepatitis or any related illnesses?					
	ncluding date of consultations, their resulting diagninformation.				
Date of Consultation	Name and Address of Doctor	Diagnosis			
Is there anything in the patient' Yes	s medical history which would have increased the risk	ι of Fulminant Viral Hepatitis?			
Yes If yes, please provide details in		diagnosis, name and address of atte			
Yes If yes, please provide details i	No ncluding the date of consultations, their resulting of	diagnosis, name and address of atte			
Yes If yes, please provide details doctor. Please state source of	No ncluding the date of consultations, their resulting cinformation.	diagnosis, name and address of atte			
Yes If yes, please provide details doctor. Please state source of Date of Consultation Please give details of the pat	No ncluding the date of consultations, their resulting of information. Name / Address of Doctor	Diagnosis Diagnosis			
Yes If yes, please provide details doctor. Please state source of Date of Consultation Please give details of the pat (including the relationship, nature)	No ncluding the date of consultations, their resulting of information. Name / Address of Doctor ent's family history which would have increased the	Diagnosis Diagnosis e risk of having Fulminant Viral He			

16.	Please give details of the patient's habits day. Please state source of information.	in relation to alcohol consumptic	on, including the	e amount of alcohol consumption pe		
17.	Does the patient have or ever had any oth	-	· 	□ No		
	yes, please provide details including dates of consultations, their resulting diagnosis, the name and address of attendin octor. Please state source of information.					
	Date of Consultation	Name / Address of Docto		Diagnosis		
D.	ADDITIONAL INFORMATION					
18.	8. Please provide us with any other additional information that will enable the Company to assess this claim.					
l he	reby certify that the above statemer	nts are true and complete to	the best of m	ny knowledge and belief.		
		,		,		
	Name of Attending Physician (Please print)		Degree/Specialty			
	Signature		Date Signed			
	PRC Number / PT	R Number	Tele	phone 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.