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 Heart Attack

Patient's Name

_____

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

A. GENERAL INFO MATION

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 (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

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 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. Has the patient previously suffered from a heart attack by any related illnesses, e.g., hypertension, angina or other vascular disease? ☐ Yes ☐ No

   If yes, please provide details, including diagnosis, date of diagnosis and treatment given.

9. (a) What were the ECG findings indicative of new myocardial infarct? Please provide details.

   (b) Was there a current history of typical chest pain and/or shortness of breath? ☐ Yes ☐ No

   (c) Was there death of a portion of the heart muscle? ☐ Yes ☐ No

   If yes, please provide details.

   (d) Was there a diagnostic elevation of cardiac enzyme CK-MB? ☐ Yes ☐ No
   If yes, please provide details.

   (e) Was there a diagnostic elevation of cardiac enzyme Troponin (T or I)?
   If yes, please provide details. ☐ Yes ☐ No

10. What was the left ventricular ejection fraction at initial diagnosis? Please provide date of test and specification of type of test.

11. Was there left ventricular ejection fraction of less than 50% measured three months or more after the event?
    If yes, please provide date of test, specification of type of test and test results. ☐ Yes ☐ No

12. Please provide details of all investigations/tests performed and enclose copies of all reports, e.g. resting ECGs , exercise, stress tests, cardiac enzyme assays, imaging, coronary angiography, echocardiography, myocardial perfusion scans and other relevant hospital reports.

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

C. MEDICAL HISTORY

14. Is there anything in the patient's medical history which would have increased the risk of Heart Attack?

    If yes, please give dates of consultations, the resulting diagnosis,. the name and address of attending doctor and source of information. ☐ Yes ☐ No

15. Please give details of the patient's family history which would have increased the risk of a heart attack (including the relationship, nature of illness, date of diagnosis and source of information?.

16. 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 and source of information.

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

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

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

D. ADDITIONAL INFORMATION

19. 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.