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

Manulife China Bank Life Assurance Corporation
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
Email: phcustomercare@manulife.com

Attending Physician's Statement Major Disease /Critical Illness Hemolytic Streptococcal Gangrene

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 **Hemolytic Streptococcal Gangrene.** To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

. **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

B. DETAILS OF MAJOR DISEASE / CRITICAL ILLNESS

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

_____

_____

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

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

(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 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. (a) Do you find the infection superficial and/or deep fascia investing the muscles of an extremity or the trunk?

☐ Yes ☐ No

(b) Is immediate surgical intervention and debridement needed?

☐ Yes ☐ No

If yes, please provide procedure performed.

_____

_____

(c) Describe result of culture after surgical exploration by a specialist.

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 Hemolytic Streptococcal Gangrene and attach copies of all relevant hospital reports, laboratory and test results.

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

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 doctor. Please state source of information.

Date of Consultation	Name of Doctor / Address	Diagnosis

13. 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

14. 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.