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
Major Head Trauma

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 Admitted ___________Date of Discharge ________________Time Discharged ___________

7. What was the cause of patient's head injury? ______________________________

____

____

____

(a) Date of the incident. ________ / ____________ / ________
dd mm yyyy

(b) Is the head trauma due to an accident? ☐ Yes ☐ No

If yes, please provide details.

____

____

(c) 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 from the date of the trauma or injury? Please provide duration in hours / days / weeks.

____

____

(b) Please provide description of the functional impairment.

____

____

(c) Is the functional impairment permanent? ☐ 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 Major Head Trauma ? ☐ 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**

C. MEDICAL HISTORY

12. 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

13. 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.