

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

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 Major Organ Transplantation

Pat	ient's Name					
Atte	ending Physician's Name	Address				
Thi	s section must be completed by a qualified and registered	d physician at the expense of the claimant.				
bee		tain contingent events associated with his/her health. A claim has LANTATION. To enable us to assess the claim, we would be				
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////	End date////				
2.	When did the patient first consult you for this condition?	//				
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	s symptoms? Please provide reasons.				
5.	Did the patient consult any other doctors for these symptoms If yes, please provide details below.	s before he/she consulted you?				
	Name of Doctor	Name of Clinic/ Hospital and Address				
		4				

B. DETAILS OF MAJOR DISEASE / CRITICAL ILLNESS

(a)	What is the diagnosis?						
(b)	Date of diagnosis		//				
(c)	Please provide the name and a			,,,,		t made.	
(· /	(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						
					<u> </u>		
<u> </u>							
(d)	Date when patient was first mad	le aware of the o	diagnosis?	////	mm	/	
(e)	Was the patient admitted in the	hospital?	Yes	N	lo		
	If yes, please state name & address of hospital						
	Complaint/s						
	Date of Admission	Time Admitte	Date of I	Discharge		Time Discharged	
(f)	Date when patient was recomm			1		I	
(')	Date when patient was resemble	shaca for transp	maritation.	dd	mm	уууу	
D-	to at annual of the marion annual of			1		ı	
Da	te of onset of the major organ's ab	normality.		/_dd	mm	уууу	
(-\	Mar the terms of set on the literature		□ v □	7 N.			
(a)	Was the transplant medically ne	cessary? [Yes] No			
	If yes, which of the relevant maj	or organ treated	as irreversible and e	end stage failu	re?		
	Bone Marrow		Liver				
	Heart		Pancreas				
	Lung		Kidney				

	(b)) For bone marrow, which type of the following transplantation was performed?						
		i. Hematopoietic stem cells pro	eceded by total bone mar	rrow ablation	Yes	□ No		
		ii. Islet cell transplant			Yes	☐ No		
9.	(a)	Has major organ transplantation	peen performed?	Yes	☐ No			
		If yes, please describe the surgic	al procedure in detail.					
		If no, please describe the surgical procedure used to correct the relevant major organ.						
	(e)	Date of surgery	//	//	_			
	(f)	f) Please provide the name and address of doctor and clinic/hospital that performed the surgery.						
	Name of Doctor			Name of Clinic/ Hospital and Address				
10.	Has the patient undergone similar procedure before? Yes No If yes, please provide details including date of surgery, name and address of doctor and clinic/hospitals that performed the surgery. Please state source of information.							
				lame of Doctor / Address	Name of Clinic/Hospital / Address			
		Date of Surgery	Name of Doctor	/ Address	Name of C	Clinic/Hospital / Address		
		Date of Surgery	Name of Doctor	/ Address	Name of C	Clinic/Hospital / Address		
		Date of Surgery	Name of Doctor	/ Address	Name of C	Clinic/Hospital / Address		
l 1 .	Plea	Date of Surgery ase provide full details of any other		/ Address	Name of C	Clinic/Hospital / Address		

12.	Please provide details of ALL investigations/test performed and attach copies of results of any investigations performed. e.g. resting ECGs, exercise stress tests, cardiac enzyme assays, coronary angiography, echocardiography, surgical reports, X-rays, CT scans, myocardial perfusion scans, and any other imaging studies, laboratory evidence etc. and other relevant hospital reports.						
13.	Please provide the names and addresses of all clinics/hospitals to which the patient has been referred to or attended for this condition either with the names of the doctors consulted.						
	Date of Consultation	Name of Doctor	Name of C	Clinic/Hospital/Address			
C.	MEDICAL HISTORY						
14.	Has the patient previously su	iffered from any related illnesses?	Yes	☐ No			
	If yes, please provide date 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			
15.	Is there anything in the patient's medical history which would have increased the risk of Major Organ Transplantation? Yes No						
		ails including the date of consultations, to finformation.					
	Date of Consultation	n Name of Doctor / Ac	Name of Doctor / Address				
16.	Please provide details of the patient's family history, which would increase the risk of Major Organ Transplantation (including the relationship, nature of illness, date of diagnosis). Please state source of information.						
17.		patient's habits in relation to past and pridger day. Please state source of information					

Please provide details of the patient's habits in relation to per day. Please state source of information.	alcohol consumption, including the amount of alcohol consumpti			
	alth condition(s)? Yes No			
Name of Doctor	Name of Clinic/ Hospital and Address			
ADDITIONAL INFORMATION Please provide us with any other additional information that will enable the Company to assess this claim.				
ereby certify that the above statements are true and comp	plete 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.