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 Muscular Dystrophy

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

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 _____ / _____ / _____
   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 ILNESS

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

_____

_____

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

(c) Please provide full and exact details of the disease or condition causing Muscular Dystrophy.

_____

_____

(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

(e) Date when patient was first made aware of the diagnosis? _____ / _____ / _____
dd mm yyyy

7. Please provide details, including dates, of the extent of the patient's degenerative diseases of the muscle.

_____

_____

8. Is the degenerative disease of the muscle hereditary? ☐ Yes ☐ No

9. Is the disease characterized by progressive weakness and atrophy of the muscle? ☐ Yes ☐ No

If yes, please provide full details.

_____

_____

10. Is the diagnosis of muscular dystrophy unequivocal and made by a consultant neurologist? ☐ Yes ☐ No

If yes, please provide full details and name of the consultant neurologist.

11. Is the diagnosis supported by appropriate neuromuscular testing such as Electromyogram (EMG)? ☐ Yes ☐ No

If yes, please provide full details of the result and attach a copy.

12. Did the condition result in permanent inability to perform, without assistance, at least three of the six Activities of Daily Living?

☐ Yes ☐ No

Capabilities (What the patient can do)

Limitations (What the patient cannot do)

13. What is the prognosis of the patient and treatment plan?

14. Please provide full details of current treatment provided.

15. Has surgical procedure been performed? ☐ Yes ☐ No

16. Please provide details of all investigations/test performed and attach copies of results of any investigations performed, e.g. resting ECGs, ultrasound, surgical reports, X-rays, MRI / CT scans, neurological reports and any other imaging studies, laboratory evidence etc., and other relevant hospital reports.

_____

_____

17. 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 / Address

. **MEDICAL HISTORY**

18. Has the patient previously suffered from the condition specified above or any related illness? ☐ Yes ☐ No

If yes, please provide details.

_____

_____

19. Is there anything in the patient's medical history which would have increased the risk of Muscular Dystrophy?

☐ Yes ☐ No

If yes, please give date of consultations, the resulting diagnosis, the name and address of attending doctor. Please state source of information. _____

Date of Consultation	Name / Address of Doctor	Diagnosis

20. Please give details of the patient's family history which would have increased the risk of having Muscular Dystrophy (including the relationship, nature of illness, date of diagnosis) Please state source of information. _____

_____

_____

21. 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

22. 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**
PR 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.