

Manulife China Bank Life Assurance Corporation

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Attending Physician's Statement Major Disease / Critical Illness Occupationally Acquired HIV

Patient's Name						
Attending Physician's Name		Address				
Thi	s section must be completed by a qualified and registere	d physician at the ex	xpense of the claimant.			
bee	above name is insured with us against the happening of cerin submitted in connection with Occupationally Acquired Hi peration in the completion of this form.					
Α.	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			
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	Da	te Symptoms First Started			
	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 o	of Clinic/ Hospital and Address			

B. DETAILS OF MAJOR DISEASE / CRITICAL ILLNESS

(b)	Date of diagnosis	//			
(c)	Please provide the name and a	ddress of doctor and clinic/hospital where the diagno			
	Name of Doctor	Name of Clinic/ Hosp	Name of Clinic/ Hospital and Address		
(d)	Date when patient was first made	de aware of the diagnosis?/ dd	/		
. ,	Was the patient admitted in the lf yes, please state name & addr		□ No		
 <u>-</u>	If yes, please state name & addr		□ No		
- C	If yes, please state name & addr	ess of hospital			
- (If yes, please state name & addr Complaint/s Date of Admission	ess of hospital	Time Discharged		
- ()	If yes, please state name & addr Complaint/s Date of Admission	TimeDate of Discharge	Time Discharged		
C	If yes, please state name & addr Complaint/s Date of Admission Was the virus acquired as a res	TimeDate of Discharge Admitted ult of an accident during the course of his/her norma	Time Discharged		
- ()	If yes, please state name & addr Complaint/s Date of Admission Was the virus acquired as a res	TimeDate of Discharge Admitted ult of an accident during the course of his/her norma	Time Discharged		
- ()	If yes, please state name & addr Complaint/s Date of Admission Was the virus acquired as a res Yes If yes, please describe in detail.	TimeDate of Discharge Admitted ult of an accident during the course of his/her norma	Time		
- ()	If yes, please state name & addr Complaint/s Date of Admission Was the virus acquired as a res Yes If yes, please describe in detail.	TimeDate of Discharge Admitted ult of an accident during the course of his/her norma	Time		

	(b) Was the sero-conversion of the HIV infection occurred within six months of the accident?
	☐ Yes ☐ No
3.	Please provide full details of all treatment provided including dates and duration of each treatment.
9.	Please provide details of all investigations performed and enclose copies of all reports, e.g. biopsy reports, cytology and histopathology reports, X-rays, CT and MRI scans, other imaging studies, laboratory evidence, surgical reports and other relevant hospital reports.
10.	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.
С.	MEDICAL HISTORY
11.	Has the patient ever had any other related conditions or risk factors?
	If yes, please give dates of consultations, the resulting diagnosis, the name and address of attending doctor. Please state source of information.
12.	Does the patient have or ever had any other significant health condition(s)?

E.	ADDITIONAL INFORMATION		
13.	Please provide us with any other additional information that will enable the Company to assess the claim.		
	ereby certify that the above statements are true and comple	to to the best of my knowledge and belief	
1110	ereby certify that the above statements are true and comple	te 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)	
req	the Attending Physician : You may use additional sheets uested. If you wish, please send the form directly to Claims 8 ow.		