

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 Primary Lateral Sclerosis

Pat	ient's Name					
Attending Physician's Name		Address				
Thi	s section must be completed by a qualified and reg	istered physician at the expense of the claimant.				
bee	e above name is insured with us against the happening in submitted in connection with PRIMARY LATERAL S r cooperation in the completion of this form.	of certain contingent events associated with his/her health. A claim has SCLEROSIS. To enable us to assess the claim, we would be grateful for				
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 / / / / yy	yy End date//// yyyy				
2.	When did the patient first consult you for this condition	n?/ / / yyyy				
3.	Please state symptoms presented and date symptoms first appeared.					
	Symptoms Presented at First Consultation	Date Symptoms First Started (DD/MM/Y)				
	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 syr If yes, please provide details below.	mptoms before he/she consulted you? Yes No				
	Name of Doctor	Name of Clinic/ Hospital and Address				

(b)	Date of diagnosis	//	mm	/		
(c) Please provide full and exact details of the disease or condition causing Primary Lateral Sclerosis.			Sclerosis.			
(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)	e) Date when patient was first made aware of the diagnosis?///					
f)	dd mm yyyyy 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 Dis	scharge	Time Discharged	
	ease provide details, including dates, of the extent of the patient's progressive degenerative disorder.					

	(a)	(a) Is the progressive degenerative disorder affecting the following?	
		Motor neurons of the cerebral cortex.	
		Widespread weakness on an upper motor neuron basis	
		Progressive spastic weakness of the limbs	
		Preceded or followed by spastic dysarthria and dysphag	ia 🔲
		Combined involvement of the corticospinal and corticobe	ulbar tracts
8.	Plea	ase comment on whether the diagnosis was supported by	Electromyogram (EMG).
9.	Plea	ase provide full details of current treatment provided.	
10.	rest	se provide details of all investigations/test performed and attach copies of results of any investigations performed, e.g. ng ECGs, ultrasound, surgical reports, X-rays, MRI / CT scans, neurological reports and any other imaging studies, ratory evidence etc., and other relevant hospital reports.	
11.		ise provide the names and addresses of all clinics/hospitals to which the patient has been referred to or attended for t dition together with the names of the doctors consulted.	
		Name of Doctor	Name of Clinic/Hospital / Address
C. 12.	Has	DICAL HISTORY s the patient previously suffered from the condition specific vever minor in nature, concerning neurological symptoms	ed above or any related illness, especially any consultations, or complaints?
	HOW	vever minor in nature, concerning neurological symptoms	oi compianto: 165 190

ls	Is there anything in the patient's medical history which would have increased the risk of Primary Lateral Sclerosis?				
	Yes	☐ No			
		ns, the resulting diagnosis, the name and addre	ess of attending doctor. Please state		
	Date of Consultation	Name / Address of Doctor	Diagnosis		
		illy history which would have increased the risk			
		illy history which would have increased the risk ness, date of diagnosis) Please state source of			
(ii	ncluding the relationship, nature of illr	ness, date of diagnosis) Please state source of	f information.		
(ii	ncluding the relationship, nature of illr	ness, date of diagnosis) Please state source of	f information.		
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(ii — P ni — P	relationship, nature of illing the relationship the relat	ness, date of diagnosis) Please state source of abits in relation to past and present smoking, and source of information.	including the duration of smoking ha		
(ii — P ni — P	relationship, nature of illing the relationship the	ness, date of diagnosis) Please state source of abits in relation to past and present smoking, and source of information.	including the duration of smoking ha		
P ni P da	relationship, nature of illing the relationship the	ness, date of diagnosis) Please state source of abits in relation to past and present smoking, and source of information.	including the duration of smoking ha		

D.	ADDITIONAL INFORMATION			
18.	Please provide us with any other additional information that will enab	le the Company to assess this claim.		
l he	reby 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)		
	the Attending Physician: You may use additional sheets in uested. If you wish, please send the form directly to Claims & Dw.			