Manulife China Bank
LIFE ASSURANCE CORPORATION
a joint venture between Manulife Philippines and China Banking Corporation

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
Progressive Muscular Atrophy

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 INFORMATION

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 full and exact details of the disease or condition causing Progressive Muscular Atrophy.

_____

_____

(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 wasting of the muscles.

_____

_____

8. Is there evidence of increased spasticity as diagnosed by a consultant neurologist?

☐ Yes ☐ No

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

_____

_____

9. 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.

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

11. Please provide full details of current treatment provided.

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. Has surgical procedure been performed? ☐ Yes ☐ No

14. 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.

15. 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

C. MEDICAL HISTORY

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

If yes, please provide details.

_____

_____

17. Is there anything in the patient's medical history which would have increased the risk of Progressive Muscular Atrophy?

☐ 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

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

_____

_____

19. 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**
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.