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
Severe Rheumatoid Arthritis

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 **SEVERE RHEUMATOID ARTHRITIS**. 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 the name and address of doctor and clinic/hospital where the diagnosis was first made.

Name of Doctor	Name of Clinic/ Hospital and Address

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

(e) Was the patient admitted in the hospital? ☐ Yes ☐ No

If yes, please state name & address of hospital _____

_____

Complaint/s _____

Date of Admission _____ Time _____ Date of Discharge _____ Time _____
Admitted Discharged

7. Please describe the initial episode.

(a) Nature of episode _____

(b) Date of initial episode _____ / _____ / _____
dd mm yyyy

(c) Duration of acute symptoms _____

(d) Is patient able to return to normal activities? ☐ Yes ☐ No

If yes, please state when _____ / _____ / _____
dd mm yyyy

If no, please state the patient's current physical and physical limitations.

_____

_____

8. Is there any indication of widespread chronic joint destruction with major deformity affecting at least three major joints?

☐ Yes ☐ No

If yes, please describe which major joint is affected.

_____

9. Please indicate if your diagnosis is supported by **ALL** of the following:

(a) Morning stiffness	☐ Yes	☐ No
(b) Symmetric arthritis	☐ Yes	☐ No
(c) Presence of rheumatoid nodules	☐ Yes	☐ No
(d) Elevated titers of rheumatoid factors	☐ Yes	☐ No
(e) Radiographic evidence of severe involvement	☐ Yes	☐ No

10. Please provide details of all investigations/test performed and enclose copies of all reports and other relevant hospital reports.

11. Are the investigation findings consistent with the diagnosis of Severe Rheumatoid Arthritis? ☐ Yes ☐ No

If yes, please give details.

12. 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 and Address

C. MEDICAL HISTORY

13. Has the patient previously suffered from Rheumatoid Arthritis? ☐ Yes ☐ No

If yes, please provide dates of consultations, the resulting diagnosis, the name and address of attending doctor. Please state source of information.

Date of Consultation	Name of Doctor / Address	Diagnosis

14. Is there anything in the patient's medical history which would have increased the risk of Severe Rheumatoid Arthritis?
☐ Yes ☐ No

If yes, please give dates of consultations, the resulting diagnosis, the name and address of attending doctor. Please indicate source of information.

Date of Consultation	Name of Doctor / Address	Diagnosis

15. Please give details of the patient's family history which would have increased the risk of having a Rheumatoid Arthritis (including the relationship, nature of illness, date of diagnosis and source of information?.

16. 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

17. 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.

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.