

Manulife China Bank Life Assurance Corporation

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Attending Physician's Statement Major Disease/Critical Illness Total And Permanent Disability

Na	Name	
Ро	Policy Number/s	Claim Number
Thi	This section must be completed by a qualified and regis	tered physician at the expense of the claimant.
bee	The above name is insured with us against the happening obeen submitted in connection with TOTAL AND PERMAI grateful for your cooperation in the completion of this form.	of certain contingent events associated with his/her health. A claim has NENT DISABILITY. To enable us to assess the claim, we would be
A.	A. GENERAL INFORMATION	
1.	1. Are you the patient's usual medical doctor?	☐ Yes ☐ No
	If yes, over what period do your records extend to?	
	Start date / / / / yyyy	End date / / / / / / yyyy
	dd IIIII yyy	y dd mm yyyy
2.	2. When did the patient first consult you for this condition?	
3.	Please state symptoms presented and date symptoms	
Ο.	Symptoms Presented at First Consultation	Date Symptoms First Started (DD/MM/YYYY)
	3,	
	What / Who is the source of this information?	<u> </u>
1	In your opinion what were the likely durations of the particle.	
т.	The your opinion what were the likely durations of the par	iont a symptoma: i iodae provide redaona.
5.	 Did the patient consult any other doctors for these sym If yes, please provide details below. 	ptoms before he/she consulted you? Yes No
	Name of Doctor Name	of Clinic/ Hospital and Address

B. DETAILS OF MAJOR DISEASE / CRITICAL ILLNESS

(a)	What is the diagnosis? Please describe the full and exact diagnosis of the condition causing total and permanent disability.				
(b)	Date of diagnosis	//			
(c)	Please provide the name and address of	of doctor and clinic/hospital where the diagnosis was first made.			
N	lame of Doctor	Name of Clinic/ Hospital and Address			
(d)	Date when patient was first made aware	e of the diagnosis? ////			
,		e that the illness/condition was total and permanent.			
(e)	Date when patient was first made aware	e that the illness/condition was total and permanent. //yyy			
(e)	Date when patient was first made award dd mm y	e that the illness/condition was total and permanent.			
(e)	Date when patient was first made aware downward and a second tion was a result of an accident?	e that the illness/condition was total and permanent. //yyy Yes No on.			
(e) Is to (a)	Date when patient was first made award awa	e that the illness/condition was total and permanent. /yyy Yes No on/			
(e) Is to (a)	Date when patient was first made award awa	e that the illness/condition was total and permanent. /yyy Yes No on/			
(e) Is to (a)	Date when patient was first made award awa	e that the illness/condition was total and permanent. /yyy Yes No on/			
(e) Is to (a)	Date when patient was first made award add mm / dd mm / y the condition was a result of an accident? yes, please provide the following information Date of accident/	e that the illness/condition was total and permanent. /yyy YesNo on/ ent happened.			

	(d)	What is the prognosis?
	PAT	TIENT'S CONDITION
•		Please describe fully the nature and severity of the patient's current disability.
	(b)	Is the patient confined to a home, hospital or similar institution that provides constant care and medical attention? Yes No
	(c)	Please comment on the patient's range of movement.
	(d)	Does the patient have full power of all limbs? Yes No If no, please state which limb(s) do(es) not have full power and the corresponding muscle power?
	(e)	What is the likelihood of improvement in motor function over time?
	(f)	Please provide full details with respect to the patient's mental abilities and cognition.
	(g)	Please describe the past and current treatment provided, including any operations performed and whether it is likely t improve his/her condition.

(h)	Is the patient compliant with the recommended treatment progr If no, please elaborate.	ram? Ye:	s N	0	
(i)	What treatment is planned for the future?				
(j)	How often must the patient be on follow-up for this condition?				
(k)	Please provide all duties of the patient's usual occupation, inclu Duties Per	rcentage%	of time spent in ea		
(1)	Please provide full details of the patient's capabilities and limita Capabilities (What the patient can do)	ations in relation to	his/her usual occ	upation.	
	Limitations (What the patient cannot do)				
(m)	Is the patient able to perform all the normal duties of his/her us If yes, when is he/she expected to return to his usual occupation		Yes	□ No/	

11 1	no, when did he/she cease all work.	/	mm	_/
				,,,,
It th	ne patient is unable to return to his/her usual occupation, is	he/she able to enga	age in any occupa	ition?
If ve	es, please provide us with the following details.			
(a)	What type of occupation can he/she engage in?			
(b)	When is he/she expected to engage in these occupations	s?		
	////			
(c)	In your opinion, is the patient totally and permanently d to engage in any occupation or whatsoever or perfor thereafter. Yes No			
	If yes, when did such commence.	//	уууу	
(d)	Is the disability due to the occurrence of any of the follow	ing:		
	(i) Total and irrecoverable loss of sight of both eyes	Yes	☐ No	
	(ii) Loss by severance of two limbs at or above the wrist or ankle	☐ Yes	☐ No	
	(iii) Total and irrecoverable loss of sight of one eye and above the wrist or ankle.	loss by severance o	of one limb at or	
	If you have ticked any of the above boxes, please prov	vide details.		
(e)	Did the disability arise due to any of the following:			
) Ar	ny self-inflicted act or attempt at suicide Ye	es N]
i) Th	ne patient being under the influence of any alcohol/drug	Yes		
	Any mental or nervous disorder Yes	No 🗌		٦

	(f)	Is full recovery expected?	Y	Nd			
	lf	yes, please state the expected re	ecovery date dd	/	Ууууу		
	If	no, please state the prognosis o	f the patient's cond	tion.			
4 . I	MEDICA	AL HISTORY					
		Did the patient previously suffe	No 🔲	lness(es) that	caused the present co	ondition?	
	(b)	Is there a family history of this of the second of the sec	condition? Ye	<u>—</u>	No nature of illness, date		
		of diagnosis and source of infor					
	(c)	Is there a family history of this	condition? Ye	es 🗌	No		
		If yes, please provide informati of information.	on such as relations	ship to insured	, nature of illness, date	e of diagnosi	s and source
	(d)	Did the patient consult other					Yes
	I	Name of Doctor	Name and Addre			Consultation I	Dates
	(e)	Is the patient suffering or has s	uffered from any ot N(☐	her significant	illnesses?		
		If yes, please provide the follow	ing information to u	s:			
	ı	Name of Doctor	Name and Addre	ess of Clinic/H	lospital	Diagnosis [Date and

(f)	Please give any	other informa	tion, which you fe	el would be helpf	ul in assessment of the	e patient's claim.
ease enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the tient's claim.						
eby cer	tify that the abov	ve statements	are true and cor	mplete to the bes	st of my knowledge a	nd belief.
S	ignature Over P	rinted Name o	of Physician	 Date Sig	ned	
	Qual	ification		Address		
	PRC Number	/ PTR	Number	Telephon	e Number (s)	
			een rejected in fa pinion or course o		mptoms?	es
	lease provide det		-		mptoms?	es No
If yes, p	lease provide det	ails why this op	-	f action is taken?		es No
If yes, p	ppinion, w long is the expe	ails why this op	pinion or course o	f action is taken?	Months	es No
F	se enclo nt's clair eby cert	se enclose copies of spent's claim. eby certify that the above Signature Over P Qual PRC Number the Attending Physicianested. If you wish, ple	se enclose copies of specialist or hosp nt's claim. eby certify that the above statements Signature Over Printed Name of Qualification PRC Number / PTR I	se enclose copies of specialist or hospital reports togetlent's claim. eby certify that the above statements are true and corsection Signature Over Printed Name of Physician Qualification PRC Number / PTR Number the Attending Physician : You may use additional ested. If you wish, please send the form directly to	see enclose copies of specialist or hospital reports together with any tests nt's claim. Beby certify that the above statements are true and complete to the best signature Over Printed Name of Physician Date Signature Over Printed Name of Physician Address PRC Number / PTR Number Telephon Telephon Name of Physician : You may use additional sheets if more ested. If you wish, please send the form directly to Claims & Sett	se enclose copies of specialist or hospital reports together with any tests or similar evidence nt's claim. Beby certify that the above statements are true and complete to the best of my knowledge a Signature Over Printed Name of Physician Date Signed Qualification Address PRC Number / PTR Number Telephone Number (s) The Attending Physician: You may use additional sheets if more space is needed ested. If you wish, please send the form directly to Claims & Settlement Department

	(b) Is the patient's condition incurable	e and beyond any hope of recovery?	Yes No
	(c) Is the advent of death highly prob	able within 6 months from date of diagnosis?	Yes No
	(d) Is the advent of death highly prob	able within 12 months from date of diagnosis?	Yes No
	(e) Is the patient currently an in-patie	nt in a hospital, nursing home or hospice?	Yes No
12.		tion/test performed and attach copies of resu urgical reports, X-rays, CT scans, and any oth	
13.	Please provide the names and addres condition together with the names of the	ses of all clinics/hospitals to which the patient e doctors consulted.	has been referred to or attended for this
	Name of Doctor	Name of Clinic/ Hospital and Addr	ess
C.	MEDICAL HISTORY		
14.	Has the patient previously suffered from	n the condition specified above or any related	illnesses? Yes o
	If yes, please provide details including doctor. Please state source of informat	g dates of consultations, their resulting diagno	
	Date of Consultation	Name of Doctor / Address	Diagnosis
15.	Is there anything in the patient's med Illness? Yes	ical history which would have increased the r	isk of the condition resulting in Terminal
	If yes, please provide details including doctor. Please state source of informa	the dates of consultations, their resulting diagration.	nosis, the name and address of attending

D	ate of Consultatio	n	Name of Doctor / Address	S	Diagnosis
			amily history, which would increased illness, date of diagnosis).	ased the ris	sk of the condition resulting in Termin
Please s	tate source of infor	mation.			
					including the duration of smoking habi
				untion inclu	ding the amount of alcohol consumpti
			oits in relation to alcohol consun		
			oits in relation to alcohol consun on.		
per day.	Please state source	e of information			
Does the	Please state source patient have or evelease provide details	e of information	onher significant health conditions?	Y€	es No
Does the	Please state source patient have or evelease provide details	e of information of including do of information	onher significant health conditions?	Ye	es No
Does the	Please state source e patient have or ev lease provide deta Please state source	e of information of including do of information	on	Ye	es
Does the	Please state source e patient have or ev lease provide deta Please state source	e of information of including do of information	on	Ye	es
Does the	Please state source e patient have or ev lease provide deta Please state source	e of information of including do of information	on	Ye	es
Does the	Please state source e patient have or ev lease provide deta Please state source	e of information of including do of information	on	Ye	es
Does the lf yes, p doctor. F	Please state source e patient have or ev lease provide deta Please state source	e of information er had any oth ls including dof information Name of	on	Ye	es
Does the lif yes, p doctor. F	Please state source e patient have or evelease provide deta Please state source of Doctor DNAL INFORMATION	e of information of information Name of	on	Ye ting diagno	of Consultation/Diagnosis
Does the lif yes, p doctor. F	Please state source e patient have or evelease provide deta Please state source of Doctor DNAL INFORMATION	e of information of information Name of	her significant health conditions? lates of consultations, their result. of Clinic/ Hospital/Address	Ye ting diagno	of Consultation/Diagnosis

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.