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

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# Attending Physician's Statement Major Disease/Critical Illness Parkinson's Disease

**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 **PARKINSON'S DISEASE**. 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 _____ / _____ / _____ End date _____ / _____ / _____
   dd mm yyyy 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 Parkinson's Disease.

_____

_____

(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 degenerative diseases of the central nervous system.

_____

_____

8. Is the degenerative disease resulted from loss of pigment containing neurons of the brain? ☐ Yes ☐ No

9. Is there unequivocal diagnosis of Parkinson's Disease by a consultant neurologist? ☐ Yes ☐ No

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

_____

_____

11. Is there presence of the following condition?

i. Cannot be controlled with medication. ☐ Yes ☐ No

ii. Shows signs of progressive impairment. ☐ Yes ☐ No

iii. There is permanent inability to perform without assistance three of the six Activities of Daily Living ☐ Yes ☐ No

If yes, please provide full details of the permanent inability to perform, without assistance, at least three of the six Activities of Daily Living.

**Capabilities (What the patient can do)**

_____

_____

**Limitations (What the patient cannot do)**

_____

_____

12. Is the Parkinson's Disease considered idiopathic? ☐ Yes ☐ No

13. Is the Parkinson's Disease resulted from any of the following?

i. Drug induced ☐ Yes ☐ No

ii. Toxic causes ☐ Yes ☐ No

Is yes, please provide details.

_____

_____

14. Please provide full details of current treatment provided.

_____

_____

15. 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.

_____

_____

16. 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

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

    If yes, please provide details.

    _____

    _____

18. Is there anything in the patient's medical history which would have increased the risk of Parkinson's Disease?

    ☐ 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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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

    _____

    _____

20. 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

21. 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.**

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