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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.