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 Terminal Illness

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 **TERMINAL ILLNESS**. 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 describe the full and exact diagnosis of the condition causing terminal illness.

_____

_____

(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

(f) Date when patient was first made aware that the illness/condition was terminal. _____ / _____ / _____
dd mm yyyy

7. Is the Terminal Illness in the presence of Human Immunodeficiency Virus (HIV) infection? ☐ Yes ☐ No

If yes, please provide the date of diagnosis for HIV and attach a copy of the HIV blood test report (if any)

_____

_____

8. Please provide full details of current symptoms and treatment. What is the expected impact on the patient's survival?

_____

_____

9. What is the prognosis?

_____

10. Has active treatment and therapy now been rejected in favor of relief of symptoms? ☐ Yes ☐ No

    If yes, please provide details why this opinion or course of action is taken?

11. In your opinion,

    (a) How long is the expectancy of the patient? _____ Months

    Please explain and give supporting medical evidence to substantiate your opinion.

    (b) Is the patient's condition incurable and beyond any hope of recovery? ☐ Yes ☐ No

    (c) Is the advent of death highly probable within 6 months from date of diagnosis? ☐ Yes ☐ No

    (d) Is the advent of death highly probable within 12 months from date of diagnosis? ☐ Yes ☐ No

    (e) Is the patient currently an in-patient in a hospital, nursing home or hospice? ☐ Yes ☐ No

12. Please provide details of all investigation/test performed and attach copies of results of any investigations performed e.g. resting ECGs, exercise stress tests, surgical reports, X-rays, CT scans, and any other imaging studies, laboratory evidence etc. and other relevant hospital reports.

13. 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

14. Has the patient previously suffered from the condition specified above or any related illnesses? ☐ Yes ☐ o

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

Date of Consultation	Name of Doctor / Address	Diagnosis

15. Is there anything in the patient's medical history which would have increased the risk of the condition resulting in Terminal Illness? ☐ Yes ☐ No

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

Date of Consultation	Name of Doctor / Address	Diagnosis

16. Please provide details of the patient's family history, which would increased the risk of the condition resulting in Terminal Illness (including the relationship, nature of illness, date of diagnosis).

    Please state source of information. _____

17. Please provide details of the patient's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day. Please state source of information. _____
    _____

    _____

    _____

18. Please provide details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day. Please state source of information. _____

19. Does the patient have or ever had any other significant health conditions? ☐ Yes ☐ No

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

Name of Doctor	Name of Clinic/ Hospital/Address	Date of Consultation/Diagnosis

D. ADDITIONAL INFORMATION

20. 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.