Manulife China Bank Life Assurance Corporation

a subsidiary of: Manulife an affiliate of: CHINABANK

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 _____ / _____ / _____ 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 ILNESS

Manulife China Bank Life Assurance Corporation
a subsidiary of: Manulife an affiliate of: CHINABANK

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.

_____

Manulife China Bank Life Assurance Corporation
a subsidiary of: Manulife an affiliate of: CHINABANK

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. _____

Manulife China Bank Life Assurance Corporation
a subsidiary of: Manulife an affiliate of: CHINABANK

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.