Manulife China Bank Life Assurance Corporation

A subsidiary of Manulife An affiliate of CHINABANK

# ATTENDING PHYSICIAN'S STATEMENT MAJOR DISEASE / CRITICAL ILLNESS - OCCUPATIONALLY ACQUIRED HIV

**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 **Occupationally Acquired HIV**. 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 |
|---|---|
| | |
| | |
| | |

   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. (a) Was the virus acquired as a result of an accident during the course of his/her normal occupation?

☐ Yes ☐ No

If yes, please describe in detail.

_____

_____

If no, please indicate if the HIV infection resulted from or transmitted by any of the following:

i. Sexual activity ☐ Yes ☐ No

ii. Recreational intravenous drug use ☐ Yes ☐ No

(b) Was the sero-conversion of the HIV infection occurred within six months of the accident?

☐ Yes ☐ No

8. Please provide full details of all treatment provided including dates and duration of each treatment.

9. Please provide details of all investigations performed and enclose copies of all reports, e.g. biopsy reports, cytology and histopathology reports, X-rays, CT and MRI scans, other imaging studies, laboratory evidence, surgical reports and other relevant hospital reports.

10. 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.

## C. MEDICAL HISTORY

11. Has the patient ever had any other related conditions or risk factors? ☐ Yes ☐ No

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

12. Does the patient have or ever had any other significant health condition(s)? ☐ Yes ☐ No

**E. ADDITIONAL INFORMATION**

13. Please provide us with any other additional information that will enable the Company to assess the 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.**