Manulife China Bank
Life Assurance Corporation

A subsidiary of Manulife An affiliate of CHINABANK

ATTENDING PHYSICIAN'S STATEMENT
MAJOR DISEASE/CRITICAL ILLNESS
PRIMARY LATERAL SCLEROSIS

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 **PRIMARY LATERAL SCLEROSIS**. 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 ILNESS.

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 Primary Lateral Sclerosis.

____

____

(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

(f) Was the patient admitted in the hospital? ☐ Yes ☐ No

If yes, please state name & address of hospital____________________

____

Complaint/s ____________________

Date of Admission ____________ Time Admitted ________ Date of Discharge ____________ Time Discharged ________

7. Please provide details, including dates, of the extent of the patient's progressive degenerative disorder.

____

____

(a) Is the progressive degenerative disorder affecting the following?

Motor neurons of the cerebral cortex. ☐

Widespread weakness on an upper motor neuron basis ☐

Progressive spastic weakness of the limbs ☐

Preceded or followed by spastic dysarthria and dysphagia ☐

Combined involvement of the corticospinal and corticobulbar tracts ☐

8. Please comment on whether the diagnosis was supported by Electromyogram (EMG).

____

____

9. Please provide full details of current treatment provided.

____

____

10. 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.

____

____

11. 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

12. Has the patient previously suffered from the condition specified above or any related illness, especially any consultations, however minor in nature, concerning neurological symptoms or complaints? ☐ Yes ☐ No

If yes, please provide details.

____

____

13. Is there anything in the patient's medical history which would have increased the risk of Primary Lateral Sclerosis?

☐ Yes ☐ No

If yes, please give dates 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

14. Please give details of the patient's family history which would have increased the risk of having Primary Lateral Sclerosis (including the relationship, nature of illness, date of diagnosis) Please state source of information. ____________

____

____

15. Please give 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 and source of information.

____

____

16. Please give details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of information.

____

____

17. 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

18. 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.