Manulife China Bank Life Assurance Corporation

a subsidiary of: Manulife an affiliate of: CHINABANK

ATTENDING PHYSICIAN'S STATEMENT MAJOR DISEASE/CRITICAL ILLNESS APALLIC SYNDROME

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 **APALLIC SYNDROME**. 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.

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(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______________________________________

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Complaint/s ____

Date of Admission ______________ Time Admitted __________ Date of Discharge ______________ Time 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 mental limitations.

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8. (a) Was there universal necrosis of the brain with the brain stem remaining intact? ☐ Yes ☐ No

(b) How long have you documented the patient's condition? Please state duration. ____________________

9. Please provide details of all investigations/tests performed and enclose copies of all reports, e.g. CT scan and MRI scan reports, other imaging studies, laboratory evidence, and other relevant hospital reports.

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10 Are the investigation findings consistent with the diagnosis of Apallic Syndrome? ☐ Yes ☐ No
If yes, please give details.

____

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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 and Address

C. MEDICAL HISTORY

12 Has the patient previously suffered from stroke or any related illnesses (e.g. hypertension, transient ischemic attack, angina and other cardiovascular diseases? ☐ Yes ☐ No

If yes, please provide details.

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____

13 Is there anything in the patient's medical history which would have increased the risk of Apallic Syndrome?

☐ Yes ☐ No

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

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14 Please give details of the patient's family history which would have increased the risk of having Apallic Syndrome (including the relationship, nature of illness, date of diagnosis. Please state source of information. ______________________________

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15. 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.

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D. ADDITIONAL INFORMATION

16. Please provide us with any other additional information that will enable the Company to assess this claim.

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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.