Manulife China Bank Life Assurance Corporation

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ATTENDING PHYSICIAN'S STATEMENT MAJOR DISEASE/CRITICAL ILLNESS ALZHEIMER'S DISEASE / IRREVERSIBLE ORGANIC DEGENERATIVE BRAIN DISORDERS (DEMENTIA)

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 **ALZHEIMER'S DISEASE / IRREVERSIBLE ORGANIC DEGENERATIVE BRAIN DISORDERS (DEMENTIA)**. 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

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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 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

8. (a) Have you performed a standardized questionnaires or tests to support evidence of progressive deterioration or loss of intellectual capacity or abnormal behavior? ☐ Yes ☐ No

If yes, please provide description of result/s and attach copy of test/s done.

_____

_____

(b) Is there evidence of Alzheimer's Disease or irreversible organic degenerative brain disorders?
☐ Yes ☐ No

(c) Has there been a significant reduction in mental and social function requiring continuous care and supervision of the insured? ☐ Yes ☐ No

If yes, please state the patient's current physical and mental limitations.

_____

_____

9. Are the investigation findings consistent with the diagnosis of Alzheimer's Disease/Irreversible Organic Degenerative Brain Disorders (Dementia)? ☐ Yes ☐ No

If yes, please give details.

_____

_____

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.

Name of Doctor	Name of Clinic/ Hospital and Address

C. MEDICAL HISTORY

11. Is there anything in the patient's medical history which would have increased the risk of Alzheimer's Disease/Irreversible Organic Degenerative Brain Disorders (Dementia)?

☐ 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. Please give details of the patient's family history which would have increased the risk of having Alzheimer's Disease/Irreversible Organic Degenerative Brain Disorders (Dementia) (including the relationship, nature of illness, date of diagnosis. Please state source of information. _____

_____

_____

_____

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13. 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. Please state source of information._____

_____

_____

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

_____

_____

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.

_____

_____

D. ADDITIONAL INFORMATION

16. 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.