Attending Physician's Statement
Disability Claim

Notes:
1. Please return the completed Attending Physician's Statement to Manulife Philippines.
2. This section must be completed by a qualified and registered physician at the expense of the insured.

1. PATIENT'S PARTICULARS

Name of Patient _____ Date of Birth _____ Age _____

Occupation _____

2. CONSULTATION FOR PRESENT ILLNESS/INJURY (IES)

(a) Date of first consultation with you _____ / _____ / _____
dd mm yyyy

(b) Date of last consultation with you _____ / _____ / _____
dd mm yyyy

(c) Please state the symptoms presented and the date symptoms first appeared.

Symptoms Presented at First Consultation	Date of Consultations (DD/MM/YY)

(d) What is the source of this information? _____

If "Others", please specify _____

(e) What was the diagnosis? _____

(f) Diagnosis was first made by (name of doctor) _____

(g) Date of diagnosis _____ / _____ / _____
dd mm yyyy

(h) Date of diagnosis was made known to the patient _____ / _____ / _____
dd mm yyyy

(i) If the condition was a result of an accident, please provide the following information:

(i) Date of accident _____ / _____ / _____
dd mm yyyy

(ii) Please describe in detail how the accident happened.

_____

_____

(iii) Please describe the injuries suffered by the patient.

_____

_____

3. PATIENT'S CONDITION

(a) Please describe fully the nature and severity of the patient's current disability.

(b) Is the patient confined to a home, hospital or similar institution that provides constant care and medical attention? ☐ Yes ☐ No

(c) Please comment on the patient's range of movement.

(d) Does the patient have full power of all limbs? ☐ Yes ☐ No

If no, please state which limb(s) do(es) not have full power and the corresponding muscle power?

(e) What is the likelihood of improvement in motor function over time?

(f) What is the likelihood of improvement in motor function over time?

(g) Please provide full details with respect to the patient's mental abilities and cognition.

(h) Please describe the past and current treatment provided, including any operations performed and whether it is likely to improve his/her condition.

(i) Is the patient compliant with the recommended treatment program? ☐ Yes ☐ No
If no, please elaborate.

(j) What treatment is planned for the future?

(k) How often must the patient be on follow-up for this condition?

_____

_____

(l) Please provide all duties of the patient's usual occupation, including percentage of time spent in each.

Duties	Percentage%
_____	_____
_____	_____

(m) Please provide full details of the patient's capabilities and limitations in relation to his/her usual occupation.

Capabilities (What the patient can do)

_____

_____

Limitations (What the patient cannot do)

_____

_____

(n) Is the patient able to perform all the normal duties of his/her usual condition?

☐ Yes ☐ No

If yes, when is he/she expected to return to his usual occupation.

_____ / _____ / _____
dd mm yyyy

If no, when did he/she cease all work. _____ / _____ / _____
dd mm yyyy

(o) If the patient is unable to return to his/her usual occupation, is he/she able to engage in any occupation? ☐ Yes ☐ No

If yes, please provide us with the following details.

(i) What type of occupation can he/she engage in?

_____

_____

(ii) When is he/she expected to engage in these occupations?

_____ / _____ / _____
dd mm yyyy

(p) In your opinion, is the patient **totally and permanently disabled** as a result of bodily injury or disease and is **unable to engage in <u>any</u> occupation** or whatsoever **or perform any work for income or profit** currently or at anytime thereafter. ☐ Yes ☐ No

If yes, when did such commence. _____ / _____ / _____
dd mm yyyy

(q) Is the disability due to the occurrence of any of the following:

(i) Total and irrecoverable loss of sight of both eyes ☐ Yes ☐ No

(ii) Loss by severance of two limbs at or above the wrist or ankle ☐ Yes ☐ No

(iii) Total and irrecoverable loss of sight of one eye and loss by severance of one limb at or above the wrist or ankle. ☐ Yes ☐ No

If you have ticked any of the above boxes, please provide details.

_____

_____

(r) Did the disability arise due to any of the following:

(i) Any self-inflicted act or attempt at suicide ☐ Yes ☐ No

(ii) The patient being under the influence of any alcohol/drug ☐ Yes ☐ No

(iii) Any mental or nervous disorder ☐ Yes ☐ No

If you have ticked any of the above boxes, please provide details.

_____

_____

(s) Is full recovery expected? ☐ Yes ☐ No

If yes, please state the expected recovery date. _____ / _____ / _____
dd mm yyyy

If no, please state the prognosis of the patient's condition. _____

4. MEDICAL HISTORY

(a) Did the patient previously suffer from any related illness(es) that caused the present condition?
☐ Yes ☐ No
If yes, please provide details.

_____

_____

(b) Is there a family history of this condition? ☐ Yes ☐ No

If yes, please provide information such as relationship to insured, nature of illness, date of diagnosis and source of information.

_____

_____

(c) Did the patient consult other doctors for this illness or its symptoms before he/she consulted you?
Yes ☐ No ☐

If yes, please provide the name(s) and addresses(es) of the doctor(s) who he/she consulted.

Name of Doctor	Name and Address of Clinic/Hospital	Consultation Dates

(d) Is the patient suffering or has suffered from any other significant illnesses?
☐ Yes ☐ No

If yes, please provide the following information to us:

Name of Doctor	Name and Address of Clinic/Hospital	Diagnosis Date and Illness

(e) Please give any other information, which you feel would be helpful in assessment of the patient's claim.

_____

_____

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the patient's 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.