Manulife Financial

ATTENDING PHYSICIAN'S STATEMENT
CRITICAL ILLNESS (HEART VALVE SURGERY)

Name

NRIC Number

Policy Number

Claim Number

The abovenamed is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **HEART VALVE SURGERY**. To enable us to assess the claim, we would be grateful for your co-operation 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 duration of the patient's symptoms? Please provide reasons.

5. Did the patient consult any other doctors for these symptoms <u>before</u> 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 CRITICAL ILLNESS

6. (a) What is the diagnosis? Please describe the full and exact diagnosis of the heart disease leading to surgery.

   (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.

   (d) Date when patient was first made aware of the diagnosis ____ / ____ / ________
   dd mm yyyy

7. Date of onset of heart valve abnormality ____ / ____ / ________
   dd mm yyyy

8. Was the diagnosis supported by cardiac catheterisation? ☐ Yes ☐ No
   If yes, please give details and attach a copy of cardiac catheterisation results.

9. Was the diagnosis supported by echocardiogram? ☐ Yes ☐ No
   If yes, please give details and attach a copy of the echocardiogram report.

10. (a) Has open chest surgery been performed? ☐ Yes ☐ No
    If yes, please describe the surgical procedure in detail.
    If no, please describe the surgical procedure used to correct the heart valve abnormality.

    (b) Was the surgical procedure medically necessary? ☐ Yes ☐ No

    (c) Date of Surgery ____ / ____ / ________
    dd mm yyyy

(d) Name and address of doctor who performed the surgery

(e) Name and address of hospital where the surgery was performed.

11. Please provide full details of any other treatment provided.

12. Please provide details of all investigations/test performed and attach copies of results of any investigations performed, e.g., resting ECGs, exercise stress tests, coronary angiography, echocardiography, surgical reports, X-rays, CT scans, and any other imaging studies, laboratory evidence etc. and other relevant hospital reports.

13. 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

14. Has the patient previously suffered from any related illness of hypertension, angina, other vascular disease or rheumatic fever? ☐ Yes ☐ No
If yes, please give dates of consultations, the resulting diagnosis, the name and address of attending doctor and source of information.

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15. Is there anything in the patient's medical history which would have increased the risk of heart valve disease? ☐ Yes ☐ No
If yes, please provide full details including the date of diagnosis, name and address of attending doctor and source of information.

16. Please give details of the patient's family history which would have increased the risk of heart valve disease (including the relationship, nature of illness, date of diagnosis and source of information).

17. 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 this information.

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

19. 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

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

Signature of Doctor

Date

Address & Official Stamp

Name and Qualification (printed)