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ATTENDING PHYSICIAN'S STATEMENT
CRITICAL ILLNESS (MUSCULAR DYSTROPHY)

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 **MUSCULAR DYSTROPHY**. 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 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 CRITICAL ILLNESS

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.

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

7. Please provide details, including dates, of the extent of the patient's neurological deficit.

8. Please describe the extent of the Muscular Dystrophy.

(a) Which are the muscles involved?

(b) Was the diagnosis confirmed by an electromyogram? ☐ Yes ☐ No
If yes, please give details.

(c) Was the diagnosis confirmed by muscle biopsy? ☐ Yes ☐ No
If yes, please give details.

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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. muscle biopsy, electromyogram, serum creatinine, phosphokinace, 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.

12. Given the ADL definitions stated below, please confirm which of the following patient is able/unable to undertake:

(a) **Washing**

Is the patient able to:

Bath?	☐ Yes	☐ No
Shower?	☐ Yes	☐ No
Wash satisfactorily by other means? Please state ___________________	☐ Yes	☐ No

If no, please state why, how much assistance is required, on what date the patient became unable to perform these tasks and its duration.

(b) **Dressing**

Is the patient able to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances? ☐ Yes ☐ No

If no, please state why, how much assistance is required, on what date the patient became unable to perform these tasks and its duration.

(c) **Transferring**

Is the patient able to move from a bed to an upright chair or wheelchair and vice versa? ☐ Yes ☐ No

If no, please state why, how much assistance is required, on what date the patient became unable to perform these tasks and its duration.

(d) **Mobility**

Is the patient able to move indoors from room to room on level surfaces? ☐ Yes ☐ No

If no, please state why, how much assistance is required, on what date the patient became unable to perform these tasks and its duration.

(e) **Toileting**

Is the patient able to:

Use the lavatory? ☐ Yes ☐ No

Manage bowel and bladder functions? ☐ Yes ☐ No

Maintain a satisfactory level of personal hygiene? ☐ Yes ☐ No

If no, please state why (reason for the patient's restriction), how much assistance is required, on what date the patient became unable to perform these tasks and its duration.

(f) **Feeding**

Is the patient able to feed oneself once food has been prepared and made available? ☐ Yes ☐ No

If no, please state why and give details of the underlying problems, the amount of assistance required, on what date the patient became unable to perform these tasks and its duration.

C. MEDICAL HISTORY

13. 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 give date of diagnosis, their resulting diagnosis, the name and address of attending doctor and source of information.

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

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

16. 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.

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17. 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.

18. 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

19. 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)

Manulife (Singapore) Pte Ltd. Reg. No. 198002116D
A Manulife Financial Company
Main Office: 51 Bras Basah Road, #09-00, Manulife Centre, Singapore 189554
Tel: 67371221 Website: www.manulife.com.sg