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ATTENDING PHYSICIAN'S STATEMENT
CRITICAL ILLNESS (PARALYSIS - LOSS OF USE OF LIMBS)

Name ______________________ **NRIC Number** ______________________

Policy Number ______________________ **Claim Number** (For internal use) ______________________

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 **PARALYSIS (LOSS OF USE OF LIMBS)**. 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) (I) Was the Paralysis due to injury? ☐ Yes ☐ No
If yes, please give full details, including date and nature of injury.

(ii) Was the Paralysis due to disease? ☐ Yes ☐ No
If yes, please give full details of disease, including date of onset and extent of disease.

(d) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.

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

7. Please describe the extent of the Paralysis.

(a) Number of limbs involved :

(b) Which limbs are involved :

(c) Is there total and irreversible loss of use of the involved limbs? ☐ Yes ☐ No
If yes, please provide basis for prognosis.

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(d) Is the loss of use of the involved limbs considered complete and permanent? ☐ Yes ☐ No
If yes, please provide basis for prognosis.

8. Did the paralysis result from a self-inflicted act? ☐ Yes ☐ No
If yes, please give full details.

9. Please provide details of current treatment provided.

10. Please provide full details of all investigations/test performed and attach copies of results of any investigations performed, e.g., resting ECGs, ultrasound, surgical reports, X-rays, 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.

C. MEDICAL HISTORY

12. Has the patient previously suffered from this or any related illness? ☐ Yes ☐ No
If yes, please give dates of consultations, the resulting diagnosis, the name and address of attending doctor and source of information.

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

14. Please give details of the patient's family history which would have increased the risk of Paralysis. ☐ Yes ☐ No
If yes, please give full details including the relationship, nature of illness, date of diagnosis and source of information.

15. 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.

16. 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.

17. 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

18. 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