Manulife

ATTENDING PHYSICIAN'S STATEMENT (PERSONAL ACCIDENT)

Policy No.
Claim No. (For internal use)

To be completed by the Attending Physician/ Surgeon at Insured's expense.

1. PATIENT'S PARTICULARS

Name of Patient: _____ NRIC/Passport No: _____

Date of Birth: _____ Sex: _____ Admission No: _____ Ward No: _____

Date of Admission: _____ Date of Discharge: _____

2. DETAILS OF PATIENT'S CONDITION

(a) Date of accident: _____/ _____/ _____
dd mm yyyy

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

_____

_____

_____

_____

(c) Please describe the nature and severity of the patient's injuries/ disabilities.

_____

_____

_____

_____

(d) Were the injuries the result of the accident described above? ❑ Yes ❑ No

(e) Was the patient under the influence of alcohol or drugs at the time of the accident? ❑ Yes ❑ No

If yes, please state the following:

(i) Blood alcohol content: _____

(ii) Type of drugs consumed: _____

(f) Did the injuries result from a self-inflicted act? ❑ Yes ❑ No

If yes, please give full description.

_____

_____

_____

(g) Did the patient undergo any surgery? ❑ Yes ❑ No
If yes, please provide us the following details.

(i) Nature of Surgical Procedure performed: _____

_____

_____

(ii) Date of surgery performed: _____/ _____/ _____
dd mm yyyy

(h) Please provide the period of medical leave given to the patient.

(i) Period of Total Disability*: From _____ To _____

(ii) Period of Partial Disability**: From _____ To _____

Notes: ***Total Disability** refers to disability which prevents the patient from performing each and every duty of his/ her occupation.

****Partial Disability** refers to disability which prevents the patient from performing one or more duties of his/ her occupation.

(i) If the patient is still totally disabled, how long is the total disability expected to last?

_____

_____

(j) If the patient is still partially disabled, how long is the partial disability expected to last?

_____

_____

(k) Was the patient suffering from any illness/ infirmity which was likely to protract the period of disability?

❑ Yes ❑ No

If yes, please provide us the details.

_____

_____

_____

(l) Did the patient consult other doctors for this injury before he/ she consulted you?

❑ Yes ❑ No

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

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

(m) Has the patient been admitted to hospital before for the same injury? ❑ Yes ❑ No

If yes, please provide the following details.

Date of Admission	Date of Discharge	Name of Hospital

(n) 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.

Signature of Doctor

Date

Address & Official Stamp

Name and Qualification (printed)